Hospitals and Health Agencies

of

San Francisco

1923

A SURVEY

By

HAVEN EMERSON, M. D.

and

ANNA C. PHILLIPS

Made for

The Committee on Hospitals and Health Agencies

of the

Council of Social and Health Agencies

of

San Francisco

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Letter of Transmittal

To the Committee on Hospitals and Health Agencies of the Council of Social Agencies of San Francisco,

Sharon Building, San Francisco.

Dear Sirs:

The letter of your chairman, Dr. Ray Lyman Wilbur, of April 20th, 1923, and subsequent communications from the general secretary of the Community Chest, Mr. H. J. Maginnity, made it clear that the objects of the Survey of Hospitals and Health Agencies which I was asked to undertake were:

1. To learn the present status of the work, and relations to each other and to the community, of the various hospitals and health agencies of San Francisco.

2. To prepare a program for safeguarding health and to provide for the sick, which would meet the needs of San Francisco and could be put into effect through the influence and resources of the Community Chest.

3. To outline the relations and share of responsibility of the hospitals and health agencies in such a scheme.

4. To suggest a plan for future development which will provide for the growth of the population, not only in size but in the conception of services which the medical and social sciences recognize as essential to permit of the fullest safety and enjoyment of human life.

On June 11th the study was begun, and the field work was completed on July 21st. The analysis of the data obtained and the preparation of the report have been under way since August 20th. Miss Anna C. Phillips has been associated with me, and responsible for most of the study of administration of hospitals, and for the organization and direction of the social and statistical studies of services for the sick.

Even though you are doubtless aware of the extent to which the offices, resources in personnel and equipment, and the invaluable relations of the Council of Social Agencies and of the Community Chest, were put at our disposal, you cannot know the full measure of the patience, tact, industry and unselfish devotion to the public interest which we met throughout our period of study in San Francisco, from all to whom we appealed for information, opinion and counsel, whether they were private citizens or representatives of public or private agencies or members of the press.

A special acknowledgment is due to those who carried out the inquiry into the condition of patients recently discharged from hospital care. This study required of the field workers skill and experience in medical and social needs and resources, particularly among the sick poor.

During the three weeks when the bulk of the field observations were made, there were twenty-one persons engaged on part or full time in the study, the equivalent of ten persons on full time, while much assistance of the regular staff of your offices was given to matters directly contributing to our work.

The cost of the survey, including the preparation of the report, has been $5489.17. Printing of 1000 copies of the report as herewith presented will cost approximately $700.

Disregarding for the moment any possible benefits to accrue in the future from such a study, it is not too much to say that the economies suggested through the establishment of a central purchasing bureau, would within twelve months reimburse the Community Chest for its investment in the Survey.

Expressed in terms of added cost of hospital administration this attempt at diagnosis or analysis of a community, as to its provisions for protection against diseases and services to the sick, would add $2.18 to the cost of maintaining each of the 2782 beds in the ten hospitals reported upon in detail, or a charge of a little more than one cent ($0.011) upon each member of the community in the year 1923.

Please accept the report herewith submitted in compliance with your request and believe me,

Respectfully yours,

(Signed) Haven Emerson, M. D.

October 27th, 1923.
437 West 59th Street
New York City

REPORT OF THE SURVEY

TABLE OF CONTENTS

Survey of the Hospitals and Health Agencies of San Francisco

SECTION I

The Community of San Francisco in 1923

For convenience of reference in understanding the discussion and the relative importance of many of the matters which follow, a brief description of San Francisco so far as concerns the size, the area occupied, the economic status, age and race groups of the population, and the elementary facts of births, deaths and sickness, seems advisable.

AREA AND POPULATION

The land area of San Francisco, containing 46.5 square miles, or 29,760 acres, was on July 1, 1923, occupied by 539,038 persons, according to estimates based upon the last enumeration by the Bureau of the Census as of January, 1920. This is equivalent to a density of 18 persons per acre for the entire area. Although there are other large cities of the country with less concentration of population per acre,[1] few if any are so free from districts or blocks where there is a dangerous density of population.

The per capita property valuation of San Francisco, based on actual or 100 per cent value of real estate, improvements and personal property, is $2220 or a total of $1,196,580,000, higher than that of any city of over 500,000 population except Chicago.

Of the population under twenty years of age, which amounts to 26.2 per cent of the entire community, there is an excess of males over females of about 2500.[2]

The four important groups under twenty are about equally represented:

64.14	per	1000	of	the	population	under	5	years	of age
66.25	"	"	"	"	"	5 to 9	"	"	"
62.62	"	"	"	"	"	10 to 14	"	"	"
68.49	"	"	"	"	"	15 to 19	"	"	"

There is obviously some error in the figures offered by the San

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1 Report of Committee on Municipal Health Department Practice, U. S. P. H. S. Bulletin No. 136, July, 1923.

2 Fourteenth Census of the United States, 1920, Vol. III, page 3.

Francisco Board of Education for children from 5 to 14, owing partly to the fact that reports from private schools are not compulsory, partly to the incompleteness of teachers' class reports, and partly to the failure to take into account the 4 per cent to 6 per cent of children of these ages who should attend school but are generally not found or brought under school control.

In January, 1920, actual enumeration by the Federal Census Bureau showed there were in San Francisco, between the ages of 5 and 14 years, 32,624 boys and 32,718 girls, a total of 65,342.

In October, 1922, the San Francisco Board of Education reported 55,952 boys and girls of these ages, although since the time of the federal census of 1920 the city had gained 25,000 in population, of whom about 3200 are estimated to be children between 5 and 14 years of age. It is probably safer to use the Federal Census Bureau figures than the reports of the Board of Education in this particular.

DISTRICTS

While the city has been arbitrarily divided into four districts for the convenience of administration of the functions of the Board of Health, the facts of population, births, deaths, sickness, etc., are not recorded so that analyses can be made of the relative safety of life, or in the matter of health liabilities and assets district by district. The experience of the city of New York in assembling all its vital records by so-called sanitary areas which correspond to multiples of the census enumeration districts, has been so valuable to the social, religious, medical and health agencies of the city that it can be confidently predicted that similar advantage would follow the adoption of a comparable area basis for San Francisco's human bookkeeping.[3]

Certainly, it is impossible to give that detailed epidemiological study to race, industrial and economic groups of the population, which is required by modern science when a city of 500,000 is considered as a unit rather than as a composite of numerous distinct areas or neighborhoods, each with its separate needs and resources.

The four districts as defined in the operation of the Department of Public Health are not on an equalized area basis, and furthermore, comparable and complete reports of births, deaths and sickness are not received or tabulated for all four districts.

We must, therefore, picture the situation for the city as a whole, disregarding differences in birth, death and sickness ratios in different parts of the city, which probably vary as widely in San Francisco as in other cities. For instance, the tuberculosis mortality in the Riverside district of New York City is 50 per 100,000, while in the Bowling Green district it is 1171 per 100,000. Only by subdivision and analysis of the

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3 Statistical Sources for Demographic Studies of Greater New York, New York City 1920 Census Committee.

population of a city upon a district, or permanent equalized area basis, can the need for and distribution of preventive and relief resources be clearly understood.

VITAL STATISTICS

The three features of the population of San Francisco which bear particularly upon the problems of health and sickness are, the considerable floating population, characteristic of great seaport cities, the colony of 8000 Chinese within the city and about 5000 more in the bay region who look to San Francisco for medical relief and care, and the Italian colony in the Telegraph Hill region. Owing to the lack of district analysis of the city above referred to, and to the absence of hospital records which would make a study of sickness and deaths among the transient or non-resident population of San Francisco possible, further comment upon these particular features is impracticable.

Among the large cities of the United States, San Francisco is notable for the relatively high proportion of native white stock among its population, the high standard of living, the extent of self-support, and the consequent self-respect and absence of widespread pauperism and degradation which prevails among the recent immigrants from the South European countries, whose presence in large numbers and in congested tenement colonies has created such serious relief and medical problems in many of the eastern seacoast and industrial cities of the country:

I. Population by Age Groups Per 1000 of Total Population for New York and San Francisco, 1920

	Total Population 1920	Number Under 20 years	Ratio per 1000	Number Between 20 and 40 years	Ratio per 1000	Number Over 40 years	Ratio per 1000	Number of years Unknown	Ratio per 1000
New York	5,610,048	2,045,984	364	2,109,049	375	1,457,210	259	7,805	1
San Francisco	506,676	132,591	262	204,750	404	166,444	328	2,891	6

II. Per Cent of Populations of Native and Foreign Parentage

	Native Born Whites of Native Parentage		Native Born of Foreign Parents		Foreign Born Whites		Negro	Other Colored
		Per Cent		Per Cent		Per Cent	Per Cent	Per Cent
New York	1,164,834	29.73	2,303,082	40.98	1,991,547	35.44	2.71	.14
San Francisco	167,179	33.0	182,643	36.0	140,200	27.7	.5	2.8

III. White Population of San Francisco, 1920, by Foreign Parentage Groups (Native Born of Foreign Parents and Foreign-Born Whites)

Ireland	63,299	Switzerland	5,298
Germany	53,924	Mexico	5,180
Italy	45,599	Spain	4,208
England	23,132	Greece	3,868
Canada	12,619	Finland	2,711
Russia	12,068	Hungary	2,591
France	11,806	Portugal	2,141
Sweden	11,407	Central and South America	2,005
Austria	9,983	Others under 2000	9,923
Scotland	8,592	Mixed Foreign Parentage	20,814
Denmark	6,278		
Norway	5,397		322,843

Two further facts appear to be significant in the matter of population, the very low birth rate of the city and the high cancer death rate, which give evidence of an age grouping of the population with a higher proportion in the decades over forty than is the case in other cities with higher birth rates and lower cancer death rates. The situation can perhaps best be illustrated by the following summary for San Francisco and New York City:

	Rates per Thousand of the Population		Per Cent of Population over 40
	Birth Rate	Cancer Death Rate	
San Francisco	16.6 (June '22-May '23)	1.51	32.8 (1920)
New York	23.2 (1921)	.97	25.99 (1920)

DEATH RATES

During the twelve months, June 1922 to May 1923 inclusive, there were 7149 deaths, giving a death rate of 13.26 per 1000 of the population, without correction for non-residence, race, sex, or age. San Francisco's general death rate would be considerably lower if it were corrected for the age groups of the population, according to standard statistical practice.

The fluctuation in the general death rate from month to month is much less than is common in cities with a more rigorous climate and where wide changes of temperature distinguish the seasons. This is a fact of much importance as will be seen in studying the similar uniformity in use of hospitals throughout the year. The months of highest general death rates are January, February and March, due apparently mainly to the increase in deaths from pneumonia in these months, February and March showing also the high periods of hospital occupancy. While May and September show the least use of hospital beds, it is in June, July and August that the general death rate is lowest. (Chart B, page 45.)

More than half of the general death rate from all causes (6.78 per 1000 of the population) is due to deaths from pneumonia (.57), all forms of tuberculosis (1), violence (1.12), cancer (1.51), and diseases of the heart (2.58). The very low typhoid fever death rate (.03) gives an excellent index to the sanitary quality of water and milk supplies and the disposal of human waste.

BIRTH AND INFANT MORTALITY RATES

There were 8557 babies born in San Francisco in the twelve months June 1922 to May 1923, of whom 436 died before they were a year old, giving an infant mortality rate of 50.95 per 1000 living births. The infant mortality rate for 1922 (57), was lower than that of any city of 100,000 population or over in the United States except Seattle (49), Minneapolis (53) and Portland, Oregon (56).

The birth rate of San Francisco in 1922 was 16.6, lower than that of any of the larger cities of the country except Los Angeles (16.2). In the twelve months, June 1922 to May 1923, the birth rate was 15.8.

Of all the births reported, 10 per cent were by midwives and about 65 per cent from hospitals. No other of the large cities of the country shows so large a proportion of all maternity cases cared for in hospitals.

MATERNAL RISK RATE

In 1922 there were 8656 living births and 195 stillbirths reported, or a total of 8951 pregnancies. There were 60 deaths of mothers from causes connected with childbirth, giving a maternal risk rate of 67.03 per 10,000 pregnancies.

While this rate is not particularly high for cities in the United States, it is much higher than the maternal risk rate in several of the cities of England where rates of 38 are recorded. It is probable that the high maternal mortality is in large part due to the inadequate development of prenatal care of expectant mothers, only a small per cent of whom receive consistent medical supervision from the fourth month of pregnancy onward.

THE GENERAL SITUATION

We see San Francisco, then, as a city favorably located as to topography and climate for the maintenance of excellent sanitary standards of environment.

With a protected water supply, and the assurance of adequate increase to meet the demands of the future, with an easy and safe provision for disposal of human waste, with few, if any, of the inconveniences or hazards of industry to handicap its citizens, San Francisco faces chiefly the health problems caused by the presence of various common communicable diseases, and the widespread unfamiliarity of its people with the means of self-protection and lacking information based on modern biological science, upon which the development of sturdy, vigorous bodies and the training of alert and well-balanced minds and nervous systems depend.

Generosity and initiative, confidence and determination to succeed in providing health protection and care for the sick, have characterized San Francisco's accomplishments to date.

From now on, concerted action, accurate analysis, keen imagination and long distance planning will probably be the notable features of the universal co-operation which has crystallized in the formation of the Community Chest.

SECTION II

Services for Health and Its Protection

While it can be fairly argued that all services for the sick contribute directly or remotely to the health of the community, there are sufficient differences in function between the agencies dealing primarily with health and its protection, and those which have been created for the diagnosis and treatment of disease, to justify separate consideration of them.

For convenience of presentation we may best consider first the organization and activities of the Board of Health and then discuss under functional headings other important services developed chiefly under separate auspices and in process of transfer to public authority.

Chapter I

THE DEPARTMENT OF PUBLIC HEALTH

The method of appointment, the qualifications, and the terms of service of the members of the Board of Health meet the best standards of municipal practice. It is, however, not considered a wholly suitable situation which imposes upon the same directing body responsibility for the highly technical work of providing hospital care for the sick poor of the city and for the domiciliary care of the aged and infirm indigents, as well as for the development of the many types of medical and social resources which must be used for the protection and maintenance of health. As the city grows and the burden of these several services becomes unbearable, there will surely be needed a board of trustees for the San Francisco Hospital, with its special divisions for isolation, for tuberculosis and for leprosy, and its chain of four outlying emergency hospitals, the Relief Home, etc., which will bear the same relation to the superintendents of these institutions as the Board of Health does to the Health Officer. Progress in public health work in San Francisco would doubtless have been faster and have received more support if a great part of the time and energy of the Health Officer and of the Board of Health had not been so constantly concerned with the operation of the largest plant for the care of sickness in the city, a negative function so far as modern public health work is concerned.

The fact that the Health Officer holds his position under Civil Service rules, makes for permanency of tenure and a most desirable continuity of policy.

The annual budget for the Department of Health is presented to the Board by the Health Officer and when approved by them, is submitted to the Mayor and Board of Supervisors. Of the total appropriation of about $2.75 per capita for the Board of Health, only 57½ cents per capita was devoted to health services proper, a sum which in 1923 was less than that

appropriated for similar functions in any of the cities of the country of over 500,000 population, except St. Louis and Chicago.

Aside from the Division of Hospitals and Charities which deals with the care of the sick and the poor of the city, the functions of the Board of Health, as carried out by their executive, the Health Officer, are the following:

Sanitary supervision of public property and institutions, together with the abatement of nuisances.

Enforcement of pure food laws, including control of eating places, food handlers, meat, milk and dairy products, etc.

The control of communicable diseases, with particular attention to tuberculosis and venereal diseases, in special clinics.

Protection of maternity, infancy and childhood through prenatal and baby stations, and school medical inspection, supervision of foster homes, midwives, etc., under the Division of Child Hygiene.

Epidemiology and vital statistics.

Diagnostic laboratory service.

The services provided out of the appropriations are probably as well balanced and effective as the funds permit, but it is suggested that less emphasis upon environment and the details of sanitary supervision with a corresponding increase in the detection and isolation of the common communicable diseases of childhood would show more direct results in reducing preventable sickness and death.

It is obvious that with so very limited an appropriation for public health services, about one-half the per capita amount made available in Detroit and Toronto, the Health Officer cannot carry on many of the profitable activities recognized as fundamental. An excellent picture of a well-balanced and adequately supported municipal health department for a city of 100,000 is to be found in the Report of the Committee on Municipal Health Department Practice of the American Public Health Association, U. S. Public Health Service Bulletin 136, July 1923, pages 247 to 274.

If the Board of Health should adopt as its program the development of health services suggested in this report, it is probable that the force of public opinion and the powerful influences of the private health agencies of the city would soon be so strong in support that adequate appropriation would be obtained.

Where the two functions, care of the sick and protection of health, are carried out by the same executive or under the same department of government, it is almost inevitable that the more pressing demands of immediate suffering will be generously met while the less obvious work of prevention lags for lack of public understanding of its significance.

The work of the Department of Health has been observed and instead of including here a record of volume or quality, only such functions as are seriously handicapped or wholly unprovided for will be discussed, to point out some of the major problems which might well engage the

attention of a Health Council if such a study and program group is created under the auspices of the Community Chest.

Protection against diphtheria by the widespread demonstration of toxin-antitoxin immunization of young children (at 2 years of age) requires additional medical and nursing personnel and an expansion of educational efforts.

The problems of tuberculosis and venereal disease control are treated of later in this section, but it is obvious that satisfactory efforts at control of these diseases will depend largely upon the more complete reporting of patients by physicians, and better facilities for treatment of groups of cases.

Protection of maternity and childhood is seriously hampered by lack of personnel to supervise midwives, to offer prenatal instruction, to examine children of the pre-school age and to provide a thorough medical inspection of children in school and in industry.

Public health nursing under the Department of Public Health is carried out by 28 school nurses, 5 infant welfare nurses and 9 tuberculosis nurses. Six of the cities of 500,000 or over spend more than San Francisco per capita for their public health nursing under a health department. (San Francisco $0.07, Pittsburg $0.09, Los Angeles $0.09, Buffalo $0.093, New York $0.10, Baltimore $0.14, Detroit $0.22.)

Laboratory service and food, milk and dairy inspection are suitably provided for.

Plumbing and housing inspection are properly functions of a building department and as carried out contribute little to the health of the community.

The final step in protection of the water supply by chlorination having been made, this is no longer a sanitary problem.

The gradual elimination of privies is quickly bringing this potential nuisance and sanitary risk to an end.

Health education is wholly unprovided for and in this appears the most striking inadequacy of public service by the Board of Health.

Reports of births, deaths and sickness, the analysis of their distribution by race or nativity, by age, sex and city district, by week or month of the year in comparison with the experience in previous years and in other cities, constitute the elements of health bookkeeping and epidemiology. Provision is not made for suitable tabulation of these facts and no annual report is published, thus depriving the citizens, as well as the public and private agencies dealing with health and disease, of a means of education and valuation of work done or uncompleted, which is of the utmost importance.

In summing up the situation so far as the Health Board and its Divisions of Hospitals, Charities and Health are concerned, it appears that San Francisco, with a high per capita wealth, provides with much generosity for the sick but is rather parsimonious in its appropriations for prevention of disease. This is probably due to the lack of public information upon the subject of health, the possibility of attaining it, and the necessity of paying for it.

Chapter 2

PROBLEMS IN HEALTH SERVICE

As each of the major issues of preventive medicine has received special attention, it has become increasingly apparent that no preventable disease which is widely prevalent can be handled as a problem apart from other disease or from the social and economic problems of the entire community. Few health problems are limited to the poor or rich alone, to the factory hand or the mother in the home. As a result of a broader recognition of the interrelationship of causes and effects of diseases, we have seen first one and then another of the special campaigns and private organizations for health protection gradually enlarge the scope of their respective programs to include all groups in a community.

It is not an exaggeration to say that at present the tuberculosis, child hygiene and venereal disease programs cover an almost equally wide field and that the logical completion of any one would constitute a suitable community health service.

Similarly, mental hygiene touches very closely child hygiene work at almost every point, and heart diseases cannot be checked without further progress in control of syphilis and the communicable diseases of childhood.

Even though cancer is so nearly the burden of one age group, the relation of maternity, personal hygiene, occupation, syphilis, neglected teeth, etc., to certain types and locations of malignant growths brings the cancer campaign into necessary relationship with other fields of preventive effort.

From these brief suggestions it can be inferred that no precise separation of functions, no isolation of agencies, can be allowed in public health work, and furthermore, that in no other phase of community relationships is there a greater need of central direction, of accepted leadership and of close association among the workers to prevent confusion of opinion, duplication of effort, and waste of public and private funds.

HEALTH EDUCATION

There is at least one element in every phase of public health work upon which efforts and resources can be combined, namely, that of education in health.

San Francisco has made no provision for educational service under its Board of Health, although it is now almost ten years since the Bureau of Public Health Education was established in the Department of Health of New York City, and fifty-two of the eighty-three cities of the country of over 75,000 population carry on enough educational work to demand a head for this activity under the health officer. Thirty-nine of the eighty-three cities publish regular bulletins. Occasional lectures by the Health Officer of San Francisco, and by the doctors and nurses of the staff,

and a portable exhibit, constitute the only health educational work of the Health Department. There is no bulletin or annual report, no press service, no systematic stressing of seasonal dangers, or successes in diminishing sickness.

There is a similar lack of policy and provision for health teaching among all the private agencies, except the Tuberculosis Association, in spite of the fact that instruction to the individual is the basis of preventive work for the expectant mother, the school child, the families of the tuberculous, as carried out at the clinic and at the bedside.

The exceptions are the newspaper publicity and instructional service carried out by an organization of physicians, developed primarily to protect the medical profession and the public against the mischievous propaganda and attack of cults and quacks, and the weekly bulletin of the California State Department of Health, which has but a limited circulation in San Francisco, chiefly among the doctors, nurses, teachers and ministers.

Of course, there are lectures given on the prevention of cancer, on child hygiene, on tuberculosis, etc., to occasional audiences, but there is nothing in San Francisco that can be called an educational policy for any age group or class of the community, planned and carried out year after year with the definite object in view of giving the reading and understanding public all they can use of the abundant knowledge of the causes and means of preventing disease.

Nor is there in the schools of the city such a system of progressive teaching of health habits, of the simple facts of biology, and of their application to the common situations of personal, family and community life as will arm the child against preventable disease, against superstition, fear and ignorance in health matters.

Until the police power of the State, as expressed in the authority of the Board of Health, and the services for the sick are supplemented by an aggressive continuous education of the community, and particularly of the school children in the meaning of health, the way it may be attained and the causes of its destruction, no permanent impression will be made upon the most important causes of human disability.

The methods, the subject matter, and the costs of public health education are well known.

To accomplish results there are needed:

(a) Inclusion of teaching of health habits, of personal hygiene, of health protection in the schools.

(b) The establishment of a division of health education, with an appropriation of approximately $20,520 [4] in the Department of Health.

(c) A conference group or committee of the proposed Health Council devoted to the study and promotion of health education by public and

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[4] Report of Committee on Municipal Health Department Practice, U. S. P. H. S. Bulletin No. 136, July, 1923, page 273.

private agencies. Membership might properly include representatives of the Board of Health, the Board of Education and of the private health agencies.

TUBERCULOSIS

San Francisco has been so favored by the initiative of its professional medical and social teachers and students of tuberculosis, that organization and services have followed closely upon plan and program, until at present most of the facilities required are provided.

Excellent analyses of the tuberculosis situation have been made within the past two years, and reports based upon these, already in the hands of the Council of Social and Health Agencies, were studied. It is not necessary to do more than refer to these careful studies and emphasize their conclusions.[5]

The following brief headings give an excellent picture of the resources, the results and the present needs as understood by the San Francisco Tuberculosis Association:

Defining the Tuberculosis Problem in San Francisco

I. MACHINERY FOR THE CONTROL OF TUBERCULOSIS

1. Bureau of Tuberculosis, Department of Public Health, with a chief in charge of six Chest Clinics throughout the city, eight visiting nurses, who follow-up patients in the homes, educate families, and bring contacts to clinic. One supervising nurse at hospital in charge of clinics and follow-up.

2. Tuberculosis Hospital, Department Public Health. Two hundred and forty beds for all types of tuberculosis in adults. Highest type of plant and medical care.

3. San Francisco Tuberculosis Association, an organization dedicated by private endeavor as a laboratory where methods for fighting tuberculosis may be initiated and demonstrated and their administration ultimately turned over to the proper public authority.

4. Semi-philanthropic institutions out of town: Arequipa Sanatorium (46 beds) for early tuberculosis in wage-earning women, for educational work and research; San Mateo Preventorium for Boys (15 beds); Stanford Convalescent Home (16 beds) for children; Hill Farm (40 beds) convalescent home for children.

5. Child Welfare Program of the Department of Public Health with eight health centers, including prenatal instruction, well-baby clinics, supervision of boarding homes for children, examination of children of pre-school drive. Also children's clinics in eight hospitals and one private health center.

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5 (a) Communication (January 16, 1922) from Dr. William C. Hassler, as Chairman of the Health Agencies Section, to H. J. Maginnity, secretary Council of Social and Health Agencies, pages 5-9.

(b) Community Resources for the Control of Tuberculosis According to Age Periods; Prevention and Treatment for the Child of Preschool Age; The School Child; The Youth (16-25), by Miss Elsie Krafft of the San Francisco Tuberculosis Association.

(c) Follow-up Study of San Francisco Tuberculosis Hospital. Presented at the California State Tuberculosis Association, February 3, 1922. Miss Elsie Krafft.

(d) Annual Report of San Francisco Tuberculosis Association, 1922. William Ford Higby, general secretary. Mortality Tables; Community Resources; Health Training; Nutrition Work.

(e) Excerpt from Report of Survey of Tuberculosis Clinics of California. National Tuberculosis Association.

6. School Health Program through co-operation of Department of Public Health, Board of Education and San Francisco Tuberculosis Association. Child Health Education in twelve schools, Nutrition Classes in twenty schools, Bread and Milk Lunches in all schools, Intensive Health Work in one school, two outdoor schools with clinic service and follow-up Board of Health nurses. Five school doctors, 23 school nurses, 7 dentists, 1 dental hygienist, 1 optometrist.

7. Health Education: Health service in dailies, Radio Health Talks, University Extension Courses, Public Health Committees, San Francisco Center.

8. Outdoor Life Program of Boy Scouts, Camp Fire Girls, Y. M. C. A., Y. W. C. A., Playground System throughout city. Many vacation camps in summer and two vacation homes for children, five for girls and young women.

9. State aid to children of tuberculous parents, free milk and eggs from five relief agencies and supplemental aid to families. Children committed to Children's Agency through Juvenile Court and given special care and supervision.

10. Legislative basis for work in regulations for pure milk and inspection, pure water and food supply, reporting of contagious diseases, interstate carriers of contagion.

II. IS THE MACHINERY EFFECTIVE?—ACCOMPLISHMENT

1. Reduction of death rate from 330 per 100,000 of population in 1900 to 109 per 100,000 in 1922.

2. Development of clinic system from one central clinic in 1909 to six clinics throughout the city in 1922. Growth of clinic attendance from 1599 in 1909 to 5981 in 1922. Three hundred and forty-six new cases in 1909 compared with 1804 new cases in 1922.

3. Development of visiting nurse system from 2 in 1908 to 8 in 1922 and 1 supervising nurse from the association, resulting in increase of home visits from 16 in 1908 to 9898 in 1922.

4. Reduction of undernourishment in children from 11 per cent in 1921 to 2.5 per cent in 1922.

5. Finest municipal tuberculosis hospital in the United States, with high type of medical care.

6. Passage of amendment authorizing country sanatorium.

III. GENERAL COMMENT

1. Not enough hospital beds. Total annual deaths, 637. Allowing one bed for each annual death, reveals the inadequacy of the present 240 beds.

2. Total annual deaths include forty-eight children under 10 years. But there is no children's ward in the Tuberculosis Hospital, and no other facilities for their care in active cases

3. Inadequate registration. Registration for 1922, 1533 active cases, or 2.4 cases to a death. Average registration in most cities, 3 or 4 cases to a death.

4. Failure to reach cases in early stages. Majority of cases admitted to Tuberculosis Hospital are moderately or far advanced. Fifty per cent die in the hospital. No sanatorium for early cases in men such as Arequipa is for women.

5. Difficulty of the migratory tuberculous. Fifty per cent of the patients in the hospital are floaters.

6. Need of better housing facilities for single homeless men.

7. Food-handling jobs, a favorite with ex-patients and no law to prevent. (Ordinance now being framed.)

8. No facilities for the industrial rehabilitation of discharged patients. (Plan now pending.)

9. Inadequate industrial health service. Only fifty welfare departments and only twelve with medical examinations. Survey being made, shows failure to recognize tuberculosis.

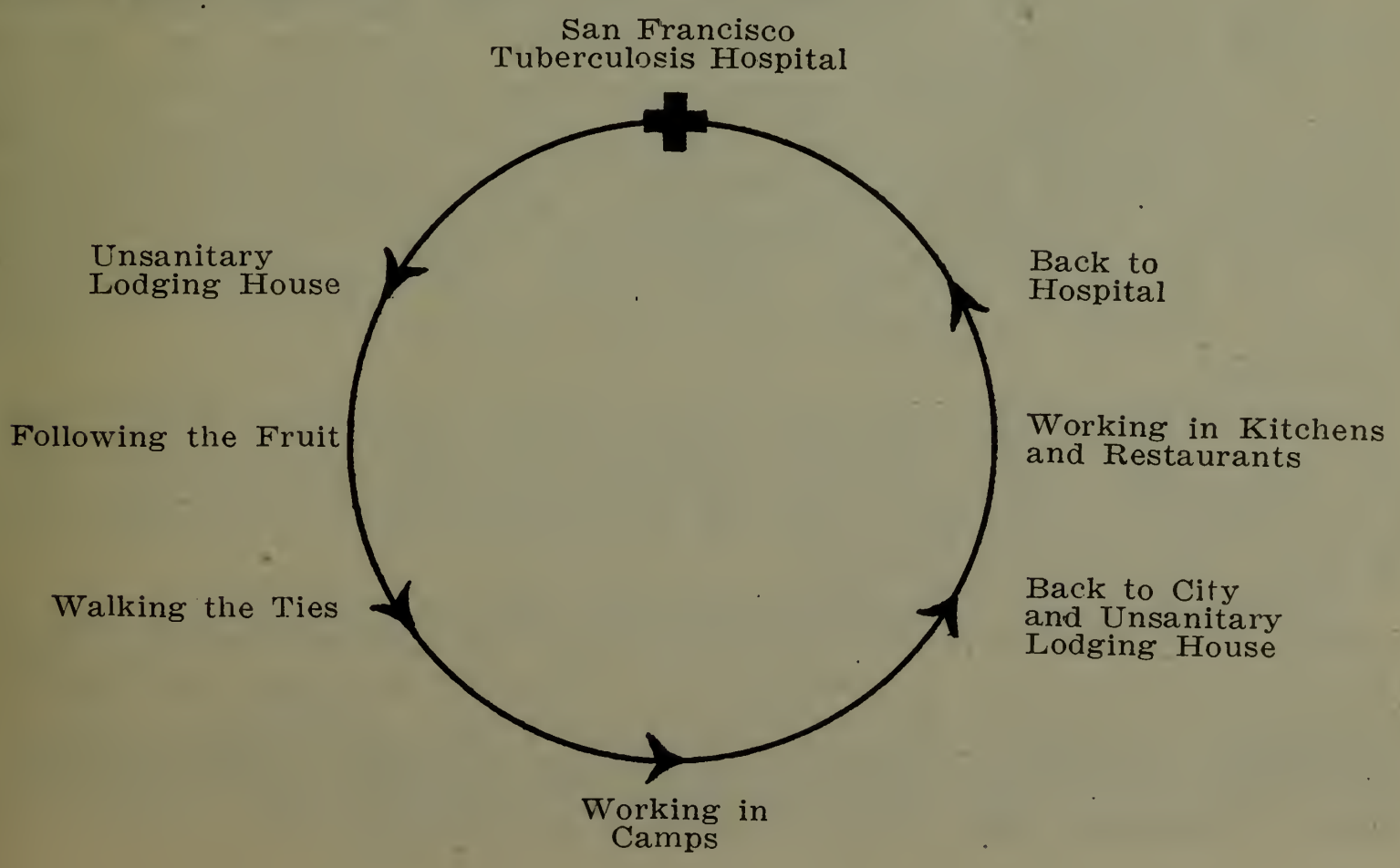
The thorough study of the subsequent history of tuberculous patients discharged from the San Francisco Hospital is a model worthy of imitation by other cities. The situation is briefly expressed in the following quotations:

The immense waste evidenced in all these figures reveals the inadequacy of one hospital unit to cope with the problem, even when that unit is supplemented with a follow-up system. The hospital renders invaluable service in the community program for control of tuberculosis by segregating and caring for far-advanced and dying cases which would otherwise be a menace to public health. But this solves only part of the problem. Three links are needed: (1) The hospital itself; (2) The country sanatorium; (3) A half-way house between the wards and the working world. Our country sanatorium is about to be realized. What is now wanted is a workshop where, under medical supervision, discharged patients could be trained in new occupations within their strength. Combined with it, but preferably under separate management and separately housed, should be a boarding-house where they could be properly fed and lodged and supervised until they reach normal health and working capacity.

It is significant that the patients reported well and working are those who had some education and training that made possible a less strenuous type of work than the average. Among them are engineers, carpenters, painters, motormen, tailors, garment-cutters, salesmen, clerks, a radio-operator, a photographer, and a mechanical dentist.

Seeking an expression of opinion on the workshop idea, a letter was sent out, and all those possible to reach personally were interviewed. Hearty endorsement came from various parts of the country, from those who were struggling on part-time work, as well as from those who had experimented successfully for themselves and wanted to see others try. While a pathetic few, concluding that the workshop was already in operation, called at the hospital to begin work.

With a country sanatorium and a workshop to make more effective the function of the hospital, undoubtedly we could change the vicious circle here represented, into a back-to-health-and-economic-efficiency cycle for a large number, with a great saving of money and medical skill:



Among the significant findings presented in the foregoing report are those dealing with the readmission of tuberculous patients to hospital care, and the subsequent history of patients discharged from the San Francisco Tuberculosis Hospital:

"Readmissions to the San Francisco Tuberculosis Hospital in a three-year period—195 patients.

Second admission	179
Third "	19
Fourth "	5
Fifth "	1

Two of the cases total ten years in the hospital on readmissions and one five years.

Of the 914 cases investigated we have these figures:

Found living	255	Left the city	175
Dead	218	Left the State	56
Still missing	441	Went to the country	61
	914	Went south	50

Of the 255 found living:

Well and working	88 or 34%
Symptoms	47
Again in S. F. Hospital	46
In other hospitals	46
In Relief Home	30
Reporting to our clinics	58"

The Annual Report of the San Francisco Tuberculosis Association for 1922 in the following important statements puts the matter tersely:

"A decline of 48 per cent in the death rate from tuberculosis is noted since 1910. The greatest decline is noticed in 1906, during the period of the earthquake and fire. The death rate in 1905 was 322.2 and in 1906, 209.8."

In the tuberculosis field alone has there been any thoroughgoing plan formulated and carried out, as far as resources permitted, for widespread instruction in the preventable causes of disease and the personal and community resources for its control. The demonstration and research work in the Daniel Webster School, in the study of the incidence and reduction of nutrition, and elsewhere in various phases of medical, social and administrative work for the tuberculous, reflects great credit upon the character of direction, initiative, and public service of the San Francisco Tuberculosis Association.

The study of the National Tuberculosis Association brings out the fact that a more nearly complete reporting of tuberculosis should and can be accomplished, and emphasizes the extent and result of shortage of beds for active cases of the disease:

There were in San Francisco County but 1205 cases reported in 1921, most of these being in the city. The number of reported cases is very low, indicating a lack of co-operation of the medical profession with the Board of Health. The Commissioner of Health has carried on a follow-up campaign to gain better co-operation, but thus far has been only partially successful. That physicians can and will co-operate, when sufficient pressure is brought to bear, is shown by the number of reported cases in New York City and Chicago.

The shortage of beds means that hundreds of far-advanced cases are living and dying in their homes, many of them among children. Eight active cases for every annual death is a conservative ratio. There are, therefore, at least 4350 active cases in San Francisco.

Attention is called also in this study to the shortage of public health nurses, to the lack of training of the nurses now engaged in this work, the special problems of tuberculosis visiting and home supervision, the need of expert supervision to raise the standard of field work, the incompleteness of clinic records and the inadequacy of home follow-up of discharged patients.

The study suggests the considerable advantages to be obtained in planning local work, by analyzing the distribution of deaths from tuberculosis by race and age groups, as expressed in the following tables:

Tuberculosis Deaths by Race and Age

Race	Deaths	Rate per 100,000
White	564	111.9
Chinese	53	725.5
Japanese	21	382.7
Negro	14	552.7

Age	No. of Deaths
Under 1 year	..
1 to 4 yrs	10
5 to 14 "	38
15 to 24 "	25
25 to 34 "	108
35 to 44 "	143
45 to 54 "	110
55 to 64 "	60
65 and over	26

CHILD HYGIENE

It has been remarked above that certain phases of public health work are so all embracing that a complete program for either one of them would constitute a satisfactory community service. Certainly if San Francisco could put into effect the entire plan for the protection of maternity and childhood which the leaders in this city in these specialties of preventive medicine have though out, the accomplishment would be notable.

The Health Officer, the teachers of pediatrics, obstetricians, women's organizations and various social agencies appear to be in entire agreement as to the desirable elements which should be included in a child health program.

Upon the structure of the health centers established primarily to reduce infant mortality, and with the well-established medical and nursing service in the public and parochial schools, both under the Department of Health, there has been built a constantly broadening service often depending upon private resources to initiate, demonstrate and popularize new phases of the work, but in the long run all functions appropriate for public operation gradually being assumed by the Board of Health as the proper burden of the taxpayer.

Recent studies have been made by the Public Health Committee of the San Francisco Center of the California Civic League upon the extent

and character of care given to the expectant mother and to the mother and child during the post-partum or neo-natal period.

That this was needed is apparent from the still high mortality rate of infants under one month of age and of mothers from puerperal causes, as can be seen from the following table:

	1918	1919	1920	1921	1922
Total Births	8466	8386	9044	9167	8656
Deaths Under One Month	115	304	325	212	289
Deaths of Mothers from Puerperal Causes	42	71	83	56	60

Prenatal supervision is recognized now as an obligation of the Health Department and of the maternity services of hospitals, but the standards of much of this work are low, the mothers are not commonly reached until they are well along in pregnancy, often in the seventh and eighth month; Wassermann reactions are not taken as a routine, education of the mothers is undertaken without a preliminary medical examination, urine tests and blood pressure observations are not made uniformly and there is rarely any follow-up of the patient in the home to secure good personal hygiene.

The standard of prenatal work at Mount Zion and at University of California and Lane and Stanford University Hospitals, is excellent.

Post-partum follow-up in the homes is not carried out adequately as a rule, though here, as in the prenatal work, both quantity and quality of service are improving.

The lack of complete prenatal and of any post partum care at the San Francisco Hospital causes much difficulty for women who must, for these periods, look to this hospital's clinics for attention.

While the effort at the Haight Street Clinic or Children's Health Center is entirely laudable as a private undertaking, it is obvious that education alone will fall short of the service needed if it is not supplemented by medical examination and supervision of the expectant mother by nurse visits in the homes and such exact methods of diagnosis as the use of the Wassermann test and tests of urine and blood pressure.

The standards adopted several years ago and steadily maintained and increased in the work of the Maternity Center Association in New York, are nowhere observed in all their completeness in San Francisco.

The time of one nurse is not sufficient to carry out adequate supervision of the 105 licensed midwives, the problems of whose nationality, education and racial customs are of themselves no small matter for adjustment to the standards of the Board of Health.

Nationalities of 105 Midwives

Italian	37	English	2
Japanese	24	Spanish	2
Russian	8	Belgian	1
United States	8	Chinese	1
German	7	Danish	1
Swiss	5	Hungarian	1
Unknown	4	Serbian	1
Austrian	2	Swedish	1

Supervision of well babies lacks only in volume of service to meet all reasonable expectations and the results to date are admirable. A report of five months' study of the whole range of health work for children was made by the Committee of the San Francisco Civic Center. The conclusions submitted express in general the best opinion of the city and should be used as the basis of arguments before the public authorities.

The substance of the matter is the fact that the appropriations for the Department of Health are too meager to provide sufficient doctors and nurses for health center, infant, pre-school, and school child supervision, and an organization which would justify and require the full time of a specialist in child health as the chief of a bureau.

This will all doubtless come about when education of the public and the public officers is insistent and continuous.

The detailed recommendations to complete the child health program prepared after individual and group conferences with those who have studied the children of San Francisco as no brief survey could possibly do, will be found in Section IV.

Too much praise cannot be given to the departments of pediatrics at the two university medical schools which have made their teaching staffs and their clinics available in countless ways to supplement the work of official and private agencies devoted to child welfare. They are carrying on active research in clinical and administrative problems in schools and health centers.

MENTAL HYGIENE

In San Francisco there is just one free bed designated for the care of patients suffering from mental disease. There are a few beds in privately supported hospitals where those able to pay three dollars a day or more can receive attention, but it must be explained that nowhere in the city is there hospital or clinic service where the resources or environment and personnel now known to be essential or at least desirable for the diagnosis, observation and treatment of mental and nervous disease, have been assembled for either the rich or the poor.

There is no greater lack in the entire scheme of hospital and health services in this city than in the field of mental disease, whether for treatment or prevention.

Fortunately, however, this rather astonishing inadequacy which is rather typical of Pacific Coast cities, is not due to rivalry or controversy among those informed on the subject.

In February of this year, the President of the Board of Health declared in no uncertain terms his conviction as to the importance of the mental problem of San Francisco, and the fact that it was a burden for the community to assume through public agencies primarily. We can do no better than to quote from his ringing appeal for a radical change in the attitude of the public toward mental disease, for a change in the method

of commitment and for immediate provision for mental disease patients in the temporary or curable stages of these states in the San Francisco Hospital (San Francisco Examiner, February 12, 1923):

There is a growing and imperative demand coming from all quarters, medical and lay, for a change in the manner of caring for and committing insane patients. This demand does not concern the acutely insane alone, but includes what are called "border-line cases" or, to use a common expression, the cases of all of those persons who are "acting queer." The demand is for provision of proper hospital conveniences for the deliberate observation of all cases of the mentally afflicted by trained psychiatrists. . . . .

As a member of the Board of Health, the conviction has been forced upon me more and more strongly in the last year or two that we are not doing our full duty when we fail to offer a place of refuge to those needy persons who are verging on mental incapacity or are subject to some form of mental disturbance. The mandate of the charter makes no distinction between the poor who are physically ill and those who are suffering mentally. It demands that we care for the sick poor. . . .

By pursuing the same course, two small wards, one for each sex, could be opened in the San Francisco Hospital, and this most important work of the care for and observation of mental cases be properly undertaken; then, when its utility had been proved beyond doubt, a separate psychopathic building could be provided.

There are in many homes in San Francisco people who are mentally affected, whose friends and relatives prefer to bear the pain and burden of caring for them in secret rather than go through the repellent process of swearing out a warrant and having a commitment to a State asylum follow. . . .

A period of observation would enable the trained psychiatrist to decide what was best for the patient, and in many cases start the sufferer on the road to recovery rather than to the asylum.

That this latter statement may not be deemed presumptuous, coming from a non-medical man, I state that an eminent psychiatrist in this city, in charge of the psychopathic ward of one of our best private hospitals, said as recently as two days ago:

"The number of cases that are committed to our State asylums for the insane that would, under proper treatment, be restored to sanity, is colossal."

The California Society for Mental Hygiene represents the expert professional, and a large sympathetic lay opinion and interest in this field, but without specific local program and support, a beginning can hardly be said to have been made in humane, just, intelligent, scientific salvaging or protection of the sick, and education or prevention among the well in the realm of mental, nervous and behavior disorders which cause so large a proportion of our delinquency, dependency and family distress.

Under the circumstances, it seemed best to obtain a body of opinion by conference with those who had given close attention to the subject, and the following statement is offered with the entire endorsement of the Survey.

The following organizations were represented at the conference: California Society of Mental Hygiene; California State Medical Society, Neuropsychiatric Section San Francisco County Medical Society; State Board of Corrections and Charities; San Francisco Board of Health; Juvenile Protective Association; Criminological Institute of San Francisco; San

Francisco Neurological Society; University of California; Stanford University; San Francisco Hospital; St. Francis Hospital.

Their report follows:

HOSPITAL BED SERVICES

We find that there are three main general hospitals in San Francisco in which the need of beds for mental cases is especially acute, viz., the University of California, Stanford University, and San Francisco Hospital..

It is estimated that the minimum need of beds in these hospitals at the present time is as follows:

University of California—Fifteen for diagnostic purposes and 25 for treatment, or a total of 40 beds.

Stanford University—Ten for diagnostic purposes and 25 for treatment, or a total of 35 beds.

San Francisco Hospital—A total of 50 beds, the capacity of the two wards now available and equipped, but without personnel, and meeting the very urgent recognized need of care for acute committable mental cases in this municipality.

We find that Mount Zion Hospital, St. Luke's Hospital, and Franklin Hospital are caring for a certain number of mental cases on a pay basis, but do not feel that they could widen the range of their services in this respect.

OUT-PATIENT CLINICS

With reference to out-patient clinics, we find that there are only two clinics daily available, viz., University of California and Stanford, and that there are four at fairly frequent intervals, viz., at Mount Zion, St. Luke's, Polyclinic, and Mary's Help Hospitals.

We feel that these should be developed further, rather than add new clinics at the present time. In each case we find that the out-patient services are woefully inadequate; patients wander from one clinic to another; there is very little contact with the home conditions or attempts to modify the same, and in each case this seems to be due to a lack of personnel, and not to the lack of vision or reasonable desires of the respective clinics.

We feel very strongly that in the two main clinics, viz., University of California and Stanford, there should be in each one specially trained neuro-psychiatric social service worker, one of the usual social service workers, one recording stenographer-clerk, and one psychologist of the standard of the American Medical Psychological Association. The relationship of psychiatric cases with courts, social service organizations and families is much wider than in any other type of medical case, and in each instance, we find that psychiatric service is inadequately equipped and suffers partly because it is a subdivision of another service.

REQUIREMENTS OF SCHOOL CHILDREN

We find, according to the last census, that there are 85,000 school children in San Francisco.

That there has never been a systematic examination of these children from a neuro-psychiatric point of view.

That there are at present one ungraded school and 18 classes for ungraded children in other schools, but that the waiting list of this sort is probably twice the number of those at present cared for.

We believe that the beginnings of juvenile delinquency are found among these children, and that the most successful preventive measures can be taken at this point. Some desultory work is being done as becomes possible at the University of California to meet conditions in certain specified schools, but this inspection is not yet completed, and in no sense gives an adequate idea of the situation in all of the schools.

We are, therefore, very strongly of the opinion that an adequate psychological and psychiatric medical inspection of these schools is very much needed, and that in San Francisco this would necessarily involve the use of full time paid psychiatric and psychological personnel and such social service workers and clerks as are requisite.

EMERGENCY COMMITMENT LAW NEEDED

There is in California at present a voluntary commitment law, which is entirely satisfactory. There is, however, no emergency commitment law, and we regret very much that it is impossible to make use of the State Hospital service unless the patient is willing to go there voluntarily. In this connection, however, we are strongly of the opinion that the mental hygiene efforts referred to above would make possible the parole of a great many cases from the State hospitals who are now retained there because of the impossibility of finding any agency to supervise them outside of the State hospitals.

Judging from the experience in other states, we are of the opinion that the saving to the taxpayer in removing these patients from State hospitals would compensate for a large part of the increased expense in developing a mental hygiene service for San Francisco.

In the various northern State hospitals, there are at present patients from San Francisco to the extent of from one-third to two-thirds of the admissions to the State hospitals, that is, some hospitals receiving one-third and some two-thirds of all their patients from the population of San Francisco.

DEMONSTRATION CLINIC FOR DELINQUENT CHILDREN

While we find a great deal of interest in San Francisco in the abstract questions of mental hygiene, we feel that it is very essential that there should be a demonstration clinic for a period of at least six months, which would show the actual conditions in San Francisco.

We believe that the question of juvenile delinquency is very closely associated with the question of the survey of school children in San Francisco, and we see no reason why the conditions should be any better in San Francisco than in Cincinnati, St. Louis, Cleveland and elsewhere.

According to the reports from these places, we may expect that San Francisco will find that two-thirds of her problems of delinquency and dependency have to do with mental hygiene. It is evident, therefore, that a demonstration of San Francisco's needs would lead to more effective effort than we have witnessed in the past.

We beg to submit that San Francisco's needs are urgent and greater than those of many cities of which we have knowledge.

This restrained, moderate and well-considered statement of fact and recommendation suggests rather than discloses the truly astonishing neglect of the most pitiful, as well as the most hopeful, of those who need medical and social care.

The Survey is deeply indebted to the authors of the foregoing statement of the situation.

VENEREAL DISEASES

(Social Hygiene)

There were reported to the Department of Health in 1922, cases, deaths and isolation in hospitals of syphilis and gonorrhea as follows:

	Cases Reported	Deaths	Hospital Admissions
Syphilis	1011	82	42
Gonorrhea	935	0	13
	1946	82	55

Of course, no such statement is to be accepted for a moment as representing even an approximation of the true situation.

The cases reported are with rare exceptions those applying for treatment at public dispensaries and hospitals. There are probably at least fifty times as many cases, not all in the communicable stages of the diseases, of syphilis and gonorrhea at any one time in the city of San Francisco. A good reporting of these diseases would be inferred if notification of 5400 cases, or 1000 for each 100,000 of the population, was made to the Health Department.

It is estimated that at least 500 cases for each 100,000 of the population (2700) will require treatment through public agencies in a year.

The report of deaths deals only with those directly and obviously due to the effects of syphilis and does not include deaths from paresis, locomotor ataxia, luetic disease of heart, arteries, or other systems and organs.

The report of hospitalization represents only those patients admitted to the San Francisco Hospital for detention purposes, as venereal diseases are not admitted under these diagnoses to any other hospitals in the city.

Since 1906 there have been various groups, medical, social, official and lay, which have for one phase or another of the problems of venereal disease, organized, started reforms and then ceased to function, until at present there is no body of informed opinion prepared to influence public or private agencies in the prevention and control of syphilis and gonorrhea.

Studies were made of hospital expenditures and days of care for venereal diseases as long ago as 1910. For a while a municipal clinic cared for the suspected common prostitutes from the "cribs" of the old "Barbary Coast." Then there was a period when attempts at sex education held the public interest. The elaborate and largely effective federal effort during the war was followed by a period of laxity in public interest and official action for protection or treatment.

Outside of the activities of the venereal disease divisions of the State and City Health Departments and the usual diagnostic and treatment services of several dispensaries, it is fair to say that nothing of a constructive, educational, recreational, social or legal character is being done in San Francisco. In spite of the efforts of several groups in the past,

many of which were productive of valuable but temporary results, nothing is now under way or apparently contemplated in the shape of professional leadership which can be relied upon to make headway against public inertia, indifference, and ignorance of this group of prevalent insidious and highly communicable and preventable diseases.

Perhaps first in importance is the incompleteness of reporting by the physicians of the city as required by law. A judicious mixture of education, of public spirit, of official pressure through the San Francisco Medical Society, the hospitals, the Health Officer and the State Department of Health might be expected to correct this. With the medical profession indifferent and resistant to reasonable requirements of the health department, education of the public will certainly lag.

There are provided for the indigent sick only two clinics for venereal diseases, in the morning and evening at the University of California Hospital and in the evening at the Lane and Stanford University Hospital. These services are of a high grade, but represent only twenty-three dispensary hours a week and do not include social or follow-up supervision of active cases sufficient to keep track of patients until they are cured. At the city prison and at the central office of the Department of Health examining and treatment stations are maintained. Co-operation among the departments of the city administration for the discovery and isolation of sex offenders who are infected is reasonably effective.

In San Francisco as in most other cities the ancient prejudice, really an expression of so-called "moral" rather than sanitary or medical opinion, against men, women or children suffering from venereal disease whether acquired "innocently" or through some a-social practices, results in the exclusion from the benefit of hospital care of these sick and suffering patients.

This self-righteousness of hospital administrations bears heavily upon patients needing bed care during some period of the course of their disease and contributes to the neglect of intensive and adequate treatment which permits a prolonged period of communicability of many patients.

Beds in every general hospital, and in certain types of cases beds in general medical or surgical wards for men and women should be made available for cases of syphilis and gonorrhea in the communicable stages. Hospital technique under all but the crudest of conditions is quite adequate to prevent the transmission of infection to other patients.

If there should be established a Health Council, representative of all the interests of public bodies in health, it would seem essential that a subcommittee or functional group be organized within its members to assume responsibility for studying the venereal disease situation in San Francisco, to reassemble the many scattered elements of interest of the groups formerly active in this field, to prepare a program of practical nature embracing the preventive resources of social, educational, recreational and sanitary character as well as the facilities required for treatment and rehabilitation of the sick, and then to develop public opinion and resources to put plans into effect.

HEART DISEASES

With the great reduction in the death rate from tuberculosis to 100 per 100,000 of the population, attention has been drawn more than ever to the heavy loss of life from what is now the leading cause of death—organic diseases of the heart. For every 100,000 of the people of San Francisco, 258 died in 1922 from heart diseases, while 151 died of cancer, 112 of violence and 100 of tuberculosis. As has been suggested in Section I, the relatively high proportion of persons of the later decades of life is in part responsible for San Francisco's particularly high death rate from heart diseases and cancer.

It is but natural that the leading cause of human deaths should develop a demand for prevention or an explanation of our limitation or helplessness in the matter. It is well known that cardiac disease of children may be due to neglect of infections of tonsils and teeth, of convalescence after rheumatic, choreic, and other infectious fevers, and that syphilis is the original infection which leads to many an adult death from aneurysm and other diseases of the heart and arteries.

San Francisco has shared, like many of the larger cities of the country, in providing special clinics for the diagnosis and supervision of heart patients, particularly children who can be spared much subsequent disability by medical guidance, home instruction, vocational training and suitable placement in work. Cardiac clinics are in operation at the University of California, Lane and Stanford University, Mount Zion and Children's Hospitals. No educational effort is under way to teach the special need of avoiding exposure to infection where infection of the heart has been once established.

Heart patients, more than any other group, except perhaps the tuberculous and mental patients, need periods of convalescent care under favorable country conditions. There are in the immediate vicinity of New York, more than 300 beds for such patients (not chronic invalids). San Francisco is about to have its first facility of this character, made available for children at the Stanford Convalescent Home at Palo Alto.

In New York City, as many cases of heart disease are in attendance at the forty cardiac clinics as attend the thirty-one tuberculosis clinics and still the need of service and possibilities of protection and prevention continue to expand.

Those who already see the importance of this problem from the social as well as the medical point of view might well associate themselves under the auspices of a Health Council to permit a crystallization of opinion in support of some such program as is now being developed in Boston, Philadelphia, St. Louis, Chicago and New York.

CANCER

We are only in the infancy of our efforts to make progress against the high mortality from cancer. The more careful studies of recent years make it appear probable that cancer is not increasing as a cause of death, except to the extent that the average duration of life has been extended

so that many more people reach the decades of life in which cancer commonly occurs, or because in one or other community, owing to climatic or economic reasons, there is an unusual preponderance of persons of forty years of age and over, among whom deaths from cancer are sure to occur in larger numbers than in populations of lower average ages.

Furthermore, there is accumulating definite evidence to the effect that in respect to certain cancers of the surface or orifices of the body, reduction of death rates has been accomplished by the application of the same type of resources which have been effective in other diseases such as tuberculosis, namely, early accurate diagnosis and appropriate treatment by removal or destruction of the localized disease process. Cancer is properly considered a preventable cause of death not only on account of the successes of surgery, but from the fact that we now know a great many of the causes of origin of cancer due to repeated local injury, irritation, and damage to tissues of the body by occupation, habits and infectious processes.

San Francisco has shared with the rest of the country in the educational efforts of the surgeons of the city who have given liberally of time to teach the public all that is proved of the causes and means of control or cure of cancer. These educational services have been periodic and have usually been a part of national efforts initiated by the parent society of which leading surgeons of San Francisco are the regional representatives.

San Francisco, Sacramento and Los Angeles lead the cities of the United States in the rate of cancer mortality. It is becoming of increasing importance to all parts of the country that each community should study its own situation and thereby contribute specific facts not only as a guide for its local educational and preventive efforts, but for the benefit of the whole nation. While in the past, most of the analysis of the cancer situation, as was the case twenty-five years ago in the tuberculosis field, was through study of deaths and death rates, it is obvious that progress can hardly be made further without records of the incidence of the condition, the immediate causes and the conduct of those afflicted, with special reference to the promptness of diagnosis and the adequacy of the treatment obtained.

Reporting of the diagnosis of cancer to the Department of Health, without implying that the public authorities should have any jurisdiction over the patient or his treatment, would make possible a body of information of the utmost importance.

Education of the public in the preventable and curable aspects of cancer and in the necessity of personal alertness and attention to warning signs and symptoms of the early stages of cancer, might properly be undertaken as part of any broad program of public education in health and its protection.

From the point of view of the sick cancer patient, San Francisco has not met her obligations, or shall we say, her opportunities for service.

Hospital beds for inoperable cases of cancer are almost unobtainable, and especially for the poor. Definite provision at the San Francisco and other general hospitals might be made in the medical or surgical wards for cancer patients for whom home care is impracticable.

When there is a visiting nurse service throughout the city, it will probably be found that large numbers of cancer patients are in need of attention whose miserable state at present is only relieved by death. Hospital care in homes for incurable disease is a humane service which would meet the needs of those for whom the general hospitals or home nursing are inappropriate or impractiable.

It would seem that the problem of cancer is worthy of separate and special consideration by a sub-committee of such a Health Council as is suggested.

PERIODIC HEALTH EXAMINATIONS

It will have been noticed in the reading of the preceding text dealing with the larger problems of preventive medicine that the essential for protective as well as for curative medical service is a thorough medical examination. To an increasing degree those planning well-proportioned campaigns for disease prevention at all ages, realize the dependence of every phase of the work upon examination of apparently healthy persons, at such intervals as will secure a continuance of health, and give a sound basis for individual advice in avoiding such errors of habit, conduct, or exposure to disease, or the effects of advancing years, as commonly interfere with health.

In addition to the emphasis necessarily placed upon such health examinations by those particularly interested in tuberculosis, child hygiene, heart diseases, etc., a truly impressive contribution to the health of the community would result from the adoption of a policy on the part of every institution and agency, public or private, co-operating under the Council of Social Agencies, or the Community Chest, whereby every member of the staffs and directing bodies should have an annual health examination, preferably by their own family physician. Such an example would not only add materially to the health assets in terms of years of fruitful, happy work, and enjoyment of life of those engaged in community service of many kinds, but it would go far to develop the habit of such a precaution throughout the population.

Such a personal annual health stock-taking at the hands of a competent physician is the least that any individual can do to contribute to his own and the community's health.

In the realm of social and relief work, intelligent, constructive family case service cannot be given unless there is a thorough medical examination provided for each member of the family before final decision is reached regarding the provision for individual or family rehabilitation.

The importance of medical health examinations has recently received especial endorsement from the American Medical Association and from the member associations of the National Health Council. The necessity of a public facility for health examinations of dispensary clientele, and for the teaching of medical students, has been recognized by the University of California Medical School in the proposal to establish a health clinic at the University of California Hospital dispensary in the immediate future.

A SAN FRANCISCO HEALTH COUNCIL

The Committee on Hospitals and Health Agencies of the Council of Social and Health Agencies of San Francisco is charged with the same kind of double function which has been criticized above in the consideration of the Board of Health and its direction of the San Francisco Hospital and the Department of Public Health.

It will appear reasonably clear from a reading of the facts presented in Section III that the care of the sick by hospitals and dispensaries is susceptible of great improvement, from the point of view of quality, quantity and costs. There have been presented above brief discussions of a few of the more important public health problems of San Francisco, with here and there a suggestion that study and planning must be undertaken seriously if accomplishment is to keep pace with the established facts of science and the reasonable desires of good citizenship.

These two truly great fields of human endeavor, namely, to give the best of care to the sick, and to develop and protect health, though closely bordering upon each other at many points, are so different in their content that they require quite separate and distinct groups for their analysis and promotion.

If the Committee on Hospitals and Health Agencies should resolve itself into two groups, one possibly called a Hospital Council and serving functions described in some detail in Section III, the other a Health Council devoted to the study and development of such projects as have been dealt with above in Section II, both types of public service would receive much needed stimulation with a promptness not otherwise likely.

If such a group or council, devoted to the health problems of the community, were created from among the considerable number of competent and public spirited men and women interested and professionally trained in one or more of the aspects of health protection, who are now available in San Francisco, they would require a permanent paid secretary to be their executive officer, not simply to carry on office correspondence, but to assemble facts, make original inquiries into the work of health agencies and prepare matters for the consideration of the various sub-committees which would be held responsible for the formulation of programs or recommendations.

Sub-committees would be called for and appointed from those without as well as within the membership of the Health Council, according to the changing needs from year to year, but in all probability for a long time to come there will be a use for standing committees devoted to such leading subjects as have already enlisted much public support. There might well be committees on: Public Health Education, Health Department Practice, Child Hygiene, Mental Hygiene, Cancer, Heart Disease, Social Hygiene and Visiting Nursing.

The San Francisco Tuberculosis Association would be to all intents and purposes the committee on tuberculosis of such a Health Council.

SECTION III

Services for the Sick

While care of the sick in bed in hospitals, or the walking patient at the dispensary, may have expressed the full conception of service in this field in the past, at present the vision of curative and preventive medicine calls for other institutions better suited to the needs of certain groups of invalids, and for the collaboration of the professions trained to teach health and to complete medical care by social assistance.

The best that can be provided for the patient with ample means, by the attention and continuous guardianship of the private practitioner of medicine, is more and more found to be practicable for the wage earner and the dependent family, through the correlation of services offered by public or privately supported agencies.

Without attempting to outline the entire range of institutions and organizations which may at one time or another be called upon to assist in the process of re-establishing the sick in health of body and mind, it has been considered by this Survey that in addition to Hospitals and Dispensaries, recognized as public services of much importance to the safety and comfort of the community, the following auxiliary or interlocking agencies are similarly essential: The Visiting, Public Health or District Nurse Association, Medical Social Service, Convalescent Homes, and Homes for Incurable or Chronic Invalids.

All of these agencies, through the suitable co-operation of which the sick are helped to regain health, or to prolong life without unnecessary suffering or disability, are so intimately related to each other in any complete plan for modern service to the sick, that the adequacy of each in a community must be studied before recommendations can be offered for changes or extension of any of the others.

HOSPITAL PROVISIONS AND COMMUNITY NEEDS

In studying the particular place filled by a group of hospitals, it is necessary to picture them in relation to the total hospital facilities and to appraise their contributions in connection with the generally accepted standards of hospital service.

San Francisco has nineteen hospitals exclusive of those maintained for the convalescent, insane, incurable, aged and infirm. As in other cities, these represent two general types of institutions: (a) those hospitals which have been gradually built up by voluntary effort or public taxes for the community as a whole, and (b) proprietary institutions which, growing up spontaneously as business enterprises, furnish service for the sick comparable to that of the private school in the field of education

which serves only special social, religious or economic groups or a clientele limited by trade, occupation, race, etc.

The following table indicates the hospital accommodations under public and private control, and of the latter, those which accept funds as charitable institutions, and those which are maintained as commercial enterprises:

Hospital Facilities of San Francisco*

Public Institutions

	Beds	
San Francisco Hospital (supported by City Taxes)	893	
University of California Hospital (supported by State Taxes)	282	1175

Privately Controlled Institutions

ACCEPTING FUNDS AS CHARITABLE INSTITUTIONS—

Children's Hospital	275	
Franklin Hospital	214	
French Hospital	200	
Lane and Stanford Hospital	314	
Mary's Help Hospital	147	
Mount Zion Hospital	150	
Shriner's Hospital	50	
St. Joseph's Hospital	202	
St. Luke's Hospital	141	
St. Mary's Hospital	166	1859

MAINTAINED AS COMMERCIAL ENTERPRISES—

Dante Sanatorium	65	
Florence N. Ward Hospital	50	
Hahnemann Hospital	112	
Morton Hospital	100	
Southern Pacific Hospital	250	
St. Francis Hospital	325	
Union Plant and Alameda Works Hospital (Bethlehem Shipbuilding Corporation)	24	926
Total		3960

None of the privately supported hospitals accepting voluntary contributions as charitable undertakings, receive public funds, there being in San Francisco no system of public subsidy for the care of the indigent sick in other hospitals than those maintained by taxation. With the exception of two institutions, which have not applied for appropriations from the Community Chest, all of the private charitable hospitals receive Chest support. The two exceptions in question are the Shriners' Hospital, the main public activity of the Sacred Order of the Mystic Shrine, furnishing free hospital care to children from the extreme Western States, suffering from orthopedic disabilities, and St. Joseph's Hospital, which is conducted by the Sisters of St. Joseph, and which, furnishing care chiefly to full-pay

*The following for various reasons are not included in the general hospital facilities of the community: Polyclinic Hospital, 12 beds; Molony's Hospital, 10 beds; and St. Peter's Hospital, 5 beds.

patients, has not as yet requested funds to meet the care of the free and part-pay service furnished.

The nineteen hospitals listed include those for both general and special cases of an acute and chronic nature, the special institutions receiving only such patients as are suffering from a particular type of disease or disability. Since certain of the facilities are thus available only for special conditions, the adequacy of the hospital accommodations of the city is dependent upon the distribution of the 3960 beds, according to the various medical services. These facts are shown in the following table:

Distribution of Hospital Beds by Medical Service

	Total Beds	General Services						Communicable Disease Services	
		Total Gen'l Beds	Medical	Surgical	Obstetrical	Pediatric	Used Interchangeably	Tuberculosis	All Others
Public Institutions									
San Francisco	893	523	181	256	27	59	...	250	120
University of California	282	282	79	105	30	68	...	...	...
Totals	1175	805	260	361	57	127	...	250	120
Privately Controlled Institutions									
ACCEPTING FUNDS AS CHARITABLE INSTITUTIONS—									
Children's	275	249	...	44	34	75	96	...	26
Franklin	214	214	...	...	10	...	204	...	...
French	200	200	...	...	...	...	200	...	...
Lane and Stanford Univ.	314	314	54	51	21	35	153	...	...
Mary's Help	147	147	...	...	30	...	117	...	...
Mount Zion	150	150	24	24	5	12	85	...	...
Shriner's	50	50	...	50	...	...	...	...	...
St. Joseph's	202	202	68	107	27	...	...	...	...
St. Luke's	141	141	...	...	11	...	130	...	...
St. Mary's	166	166	...	...	16	...	150	...	...
Totals	1859	1833	146	276	154	122	1135	...	26
MAINTAINED AS COMMERCIAL ENTERPRISES—									
Dante Sanatorium	65	65	...	...	...	...	65	...	...
Florence N. Ward	50	50	...	...	...	...	50	...	...
Hahnemann	112	112	...	...	...	...	112	...	...
Morton	100	100	10	80	10	...	...	...	...
St. Francis	325	325	...	...	...	...	325	...	...
Union Plant	24	24	...	...	...	...	24	...	...
So. Pacific	250	250	...	...	...	...	250	...	...
Totals	926	926	10	80	10	...	826	...	...
Grand Tot'ls	3960	3564	416	717	221	*249	1961	250	146

*This total includes 114 cribs for new-born infants, as new-born are assigned to the pediatric services in a few of the hospitals.

Experience indicates that a provision of five general hospital beds for each thousand of population is needed to afford adequate facilities for the hospitalization of general medical and surgical conditions, maternity patients and children. In addition, there are needed, for the acute communicable diseases, five beds for each ten thousand of population, and for the tuberculous, as many beds as there are deaths in the year from tuberculosis.

It has been found in the larger cities of the country that the ratio of five beds for general medical and surgical patients per thousand of the population should include five beds per 10,000 persons for children, and forty-five beds per 100,000 to hospitalize 30 per cent of the maternity patients.

Based upon the foregoing, San Francisco, with a population of 540,000 should have, as a minimum, 2700 general hospital beds, 270 beds for acute communicable diseases, and 500 beds for tuberculosis.

It is evident that, with 3564 general hospital beds available, affording 6.6 beds per thousand of population, there are sufficient facilities to meet this minimum of the city's needs.

In considering the question of ratio of beds to population, however, it should be borne in mind that the hospitals serve a much larger area than the general metropolitan district. Due to the city's prominence as the leading medical center of the Pacific Coast, patients come from distant sections of the State and from outside of the State, to take advantage of the superior facilities available for diagnosis and treatment. For example, the University of California receives patients from the entire State, several other of the institutions—the Southern Pacific Hospital and the Shriners' Hospital—accepting patients from neighboring States as well.

The extent to which non-residents use the hospitals was indicated by the Survey's analysis of the places of residence of some 6000 patients admitted to ten of the hospitals (representing 70 per cent of the total hospital facilities) during November, 1922, and January, 1923. As this study showed that 16 per cent of the patients were non-residents of San Francisco, it is believed that the true minimum number of general beds should be not less than 2970, that is, at least 10 per cent more than the minimum for the city's population alone.

The birth rate of the population of San Francisco is not over 16 per thousand of the population, and the practice of the people of San Francisco is to hospitalize at least 65 per cent of their maternity patients—the percentage hospitalized increasing steadily in recent years. It is suitable, therefore, in determining the number of beds needed for maternity care under the general heading of beds for medical and surgical patients, to alter estimates appropriate for industrial cities in the Eastern United States, where the birth rate is 20 per thousand of the population or over, and where experience shows that rarely more than 30 per cent of maternity patients are cared for in hospitals.

Instead, therefore, of providing for an estimated 30 per cent of the

8557 births reported in the twelve months ending June 1, 1923—2567—by setting aside 128 beds, that is, one bed for each twenty such hospital patients a year, San Francisco should provide hospital beds for not less than 75 per cent of the births, or 320 beds. As this is 77 beds more than the number required to hospitalize 30 per cent of the maternity patients on the population basis (243 beds), the total minimum desirable beds is thus raised from 2970 to 3047.

Based upon these accepted ratios we have thus, all told, a theoretical need in San Francisco for the 540,000 population and non-residents, as follows:

	Beds
1—General Medical and Surgical Conditions	3047
(a) Children	270
(b) Maternity	320
(c) Others	2457
2—Acute Communicable Diseases	270
3—Tuberculosis	500

By consulting the table of hospital facilities on page 29, it will be seen that the accommodations available for the foregoing groups are:

	Beds
1—General Medical and Surgical Conditions	3564
(a) Children	135*
(b) Maternity	221
(c) Others	3208
2—Acute Communicable Diseases	146
3—Tuberculosis	250

Comparison of the available and the theoretical facilities indicates that, although for the general medical and surgical conditions there are over 500 more general beds than the suggested minimum, the facilities for children are one-half and those for maternity patients one-third less than the estimated need.

The provisions for the acute communicable disease, while 124 beds less than the theoretical requirement, appear adequate, due to the low hospitalization of such conditions. In view of the foregoing, and as there are 150 beds available in case of need in the old Isolation Hospital, there is no apparent present shortage of facilities for this patient group.

The facilities for the tuberculous show a serious shortage. If we include the preventoria accepting active tuberculosis cases, there still remains a shortage of 150 beds for this important specialty, as presented in detail earlier in the report.

To sum up—Compared with the experience of other cities, San Francisco has:

(a) Ample beds for the general medical and surgical services, although there is an insufficient number of beds specifically equipped and set aside

* Exclusive of 114 beds for new-born infants.

for the care of children, and an insufficient number assigned to maternity patients.

(b) Sufficient facilities for communicable diseases in view of the limited use of hospitals for the isolation of the common communicable diseases.

(c) Need for from 150 to 250 additional beds for tuberculosis.

Chapter I

HOSPITALS

The hospitals receiving the more special attention of the Survey included the nine institutions which are receiving or have applied for funds from the Community Chest and the San Francisco Hospital, which was studied only in so far as its activities relate to the hospital and health problems studied. The ten hospitals are:

Hospitals Included in Survey

	Beds	
PUBLIC INSTITUTIONS—		
San Francisco Hospital	893	
University of California Hospital	282	1175
PRIVATELY CONTROLLED INSTITUTIONS—		
Children's Hospital	275	
Franklin Hospital	214	
French Hospital	200	
Lane and Stanford University Hospital	314	
Mary's Help Hospital	147	
Mount Zion Hospital	150	
St. Luke's Hospital	141	
St. Mary's Hospital	166	1607
Total		2782

The importance of these institutions as major community activities is indicated by the fact that, combined, they constitute 70 per cent of the total hospital facilities of the city. As a group, during 1922, they cared for approximately 50,000 patients and furnished 630,000 days of treatment. In addition those that maintain dispensary departments furnish 87 per cent of the total hours of dispensary service of the city, and, during 1922, received approximately 252,000 visits—90 per cent of the total number of visits.

The location of these institutions, together with the volume of service rendered to bed patients and out patients, is shown in Map 1 on the opposite page.

As medical agencies, they provide 94 per cent of the facilities definitely assigned to the various medical services, there being practically no formal distribution of beds in the other hospitals of the city. The magni-

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH DISTRICTS, SHOWING LOCATION OF HOSPITALS AND DISPENSARIES STUDIED AND THE VOLUME OF SERVICES THEY PROVIDED IN 1922

HOSPITALS ■ SIZE REPRESENTS NUMBER OF DAYS OF CARE - 1922

DISPENSARIES ● SIZE REPRESENTS NUMBER OF VISITS - 1922

DISTRICT 1

TELEGRAPH HILL (818 VISITS)

PRESIDIO

PRESIDIO ST.

LANE AND STANFORD UNIVERSITY (79,138 DAYS)

POLYCLINIC (10,419 VISITS)

DISPENSARY (96,645 VISITS)

CHILDREN'S (60,128 DAYS)

DISPENSARY (12,998 VISITS)

MT. ZION (44,147 DAYS)

DISPENSARY (28,520 VISITS)

FRENCH (46,663 DAYS)

LINCOLN PARK

MARKET ST.

ST. MARY'S (51,766 DAYS)

HOMEOPATHIC (1,664 VISITS)

GOLDEN GATE PARK

FRANKLIN (54,813 DAYS)

MARY'S HELP (34,379 DAYS)

DISPENSARY (11,749 VISITS)

DISTRICT 2

UNIVERSITY OF CALIFORNIA (61,059 DAYS)

DISPENSARY (90,343 VISITS)

COLSOM ST.

SAN FRANCISCO (158,027 DAYS)

SAN MIGUEL

TWIN PEAKS

DISTRICT 3

ST. LUKE'S (39,457 DAYS)

DISPENSARY (11,281 VISITS)

DISTRICT 4

RANCHO

RANCHO LAGUNA DE LA MERCED

LAGRAND AVE.

CITY LINE

PACIFIC OCEAN

BAY OF SAN FRANCISCO

MAP 1

tude of their activities is reflected in their finances, as combined, they represent a total estimated investment of over $11,000,000, with annual expenditures amounting to over $3,700,000.

Although eight of the hospitals are privately controlled, their large contributions to the community's welfare indicate that they occupy a position similar to that of public service corporations—organizations which, though privately owned and directed, minister to the common welfare by supplying community needs. The extent to which they supplement tax-supported facilities is shown in the fact that, as a unit, they furnished 16 per cent of the free bed care during 1922, and 75 per cent of the bed care of patients who paid only part of the cost of hospital service.

Their relation to the Community Chest may be briefly stated:

Of the two hospitals supported by taxes, the San Francisco has made no application for funds collected by the Chest, the University of California, through its Auxiliary, concerned with out-patient and social service activities, receiving $6000 for 1923. In addition, the last-named institution has applied directly for funds for bed care.

Six of the privately supported institutions receive Chest funds, one of them, Lane and Stanford University Hospital, receiving funds through the Stanford Clinics Auxiliary and San Francisco Maternity, the organization maintaining the hospital's Social Service Department. In addition, applications for participation in Chest funds are pending for the French, Lane and Stanford University, and St. Mary's Hospitals.

The amounts allocated to the several hospitals for 1923, in each instance corresponding to the amount obtained from charitable sources in recent years, are as follows:

Children's Hospital	$ 87,000
Franklin Hospital	15,000
Mary's Help Hospital	12,000
Mount Zion Hospital	85,000
St. Luke's Hospital	20,000
Stanford Clinic's Auxiliary and San Francisco Maternity	12,227
University of California Hospital Auxiliary	6,000
Total	$237,227

ORGANIZATION AND ADMINISTRATION

To accomplish their common end—"to care for the sick," "to aid the sick and suffering," "to give medical care and comfort to the sick," "to assist in medical education," "to train nurses," etc.—various types of governing boards have been set up with more or less well-defined organizations, committee activities, and administrative policies.

Of the two publicly supported institutions, the San Francisco Hospital is directed by the Board of Health, a combined lay and professional board

of seven men serving without remuneration. The Board meets weekly, and has finance, hospital, and building committees with definite responsibilities, and receives frequent and detailed reports of certain of the institution's activities. As it also directs all of the other activities of the Board of Health, it is not exclusively the managing board of the hospital.

Experience has demonstrated that the operation of a hospital is best served by a board whose sole function is the direction of the institution. The manifold responsibilities carried by the Board of Health and the diversified activities which it directs suggest a need for a specially appointed group, such as a board of trustees, to which it could delegate the responsibility of the direction of so important an undertaking as the hospital, the largest in the city and caring for the greatest number of patients. Other cities are adopting this method of meeting the special needs of municipal hospitals. For example, the Cleveland Hospital Council has recently made formal recommendations to the Cleveland City Council, urging the appointment of a board of trustees for the Cleveland City Hospital.

The University of California Hospital, directed by the Board of Regents of the university, is likewise but one of many activities receiving the attention of the regents. The committees of the Board, comprising Agriculture, Conference with Faculty, Educational Relations, Endowments, Engineering, Executive, Finance, Grounds and Buildings, Jurisprudence, Letters and Science, Library, Research and Publications, Lick Observatory, University of California Medical School, Southern Branch of the University of California and Scripps Institution for Biological Research, and Wilmerding School Committees, makes no special provision for the direction of the hospital's affairs.

It is the general sentiment in present day hospital operation that the lack of a directing group, whose sole function is the operation of a hospital, deprives both the staff and the hospital administration of a highly desirable contact with the responsible, policy-forming body.

The hospital is an institutional member of the American Hospital Association, and publishes no annual report.

The Hahnemann Hospital (not included among the hospitals studied in detail in this Survey), formerly the Homeopathic Hospital and acquired by the university in recent years, is maintained by the regents as a general hospital for private and industrial cases. The present policy, which appears to take small account of the medical standards at this institution, is judged unsuitable and unworthy of so responsible a board as the regents of the university. The hospital is more like a stepchild than a member of the university family, as regards its medical standards and administrative procedures.

Brief mention may be made of the directing organization of the eight privately controlled institutions:

Children's Hospital—The Children's Hospital, incorporated in 1875, for the exclusive care of sick women and children, the education of women

physicians, and the training of nurses, has a Board of Trustees consisting of five men which meets monthly and is concerned only with the finances of the institution. The direction of the hospital is centered in a Board of Women Managers of thirty, which meets monthly with an average attendance of two-thirds of its membership. The committees are Executive, Finance, Joint, Conference, Admissions, Social Service, Training School, Housekeeping, and Building. The reports considered by the Board of Managers relate to all hospital departments and to all committee activities. Although the committee organization of the board provides for committee supervision of specific activities, it is evident that many committee functions are administrative rather than directing, and that the personnel of some committees is not sufficiently comprehensive.

The Conference Committee, a joint committee of the board and medical staff, is comparatively recent and in line with present-day methods of establishing contact between directing and professional groups. At the time the institution was visited, the board had not required of its staff the usual monthly clinical conferences, nor was there any program for staff review of the medical work of the hospital. The Training School and Social Service Committees do not include all the advisable elements in their membership, and there is no Dispensary Committee, although the hospital operates a dispensary department.

The Board of Trustees has not so directed the hospital's finances that budgetary methods are used or that a financial plan is in effect.

The board, conducting a notable service to the community and holding large funds entrusted to its use for the care of the sick poor, has published no annual report since 1918. The institution has no national hospital memberships.

Franklin Hospital—The Franklin Hospital is maintained by the German General Benevolent Society, an incorporated insurance association, founded in 1854, to provide relief to men, women, and children of German origin and to maintain a medical organization and hospital for the benefit of its members. The activities of the Society are directed by a Board of Directors which meets monthly, the hospital being supervised by a Hospital Committee which meets bi-monthly. These two groups receive bi-monthly reports of finances and the activities of the hospital and the Society. The activities of an auxiliary committee composed of women are limited to the relief of beneficiaries of the Society living in their homes. The board lacks the indicated organization for the direction of hospital activities as the usual committees such as executive, finance, training school, etc., have not been established. The institution has no national hospital memberships. The annual report of hospital activities is contained in the Society's report and consists of a rather complete financial statement, but only brief statistical hospital material. The attending staff holds monthly clinical meetings, but as the board does not require complete medical histories, the review of the medical work is not complete.

French Hospital—The French Hospital, maintained by the French Mutual Benefit Society, did not furnish the Survey with the needed infor-

mation regarding organization, administration, finances, etc., the only material furnished relating to the number of patients and days of care for 1921 and 1922. The annual report of the Society indicates that the hospital, founded in 1852, is maintained to furnish hospital care to medical and surgical cases and to members of the mutual benefit association. The Society is governed by an Administrative Council of fifteen, with the usual officers. Details as to committee organization and function, hospital memberships, etc., are not known. The Society's annual report does not segregate hospital and Society income and expenditures, and presents only a meager picture of the institution's activities.

Lane and Stanford University Hospital—Lane and Stanford University Hospital has been maintained by Leland Stanford Junior University for a little over ten years as an incorporated department of the university. The hospital's affairs are directed by a Clinical Committee composed of four members of the Medical School faculty and the physician superintendent of the institution. The committee meets monthly, has the usual officers but no sub-committees, and receives complete and detailed monthly reports. There are no auxiliary committees to the Clinical Committee, although the Stanford Clinic Auxiliary and San Francisco Maternity, which maintains the Social Service Department, is in effect an auxiliary to the hospital's directing group.

As in the case of the two publicly supported hospitals, it is judged that the best interests of this institution will be served by the establishment of a lay board of trustees, which includes women members. The present organization of the institution—the hospital conducted by one group, the Out-Patient Department conducted by the Medical School and the Social Service Department conducted by a group with no formal connection with the hospital—provides separate direction and financial responsibility of activities which are essentially administrative departmental units of the hospital.

The hospital has no national memberships. It publishes an interesting and rather full annual report of hospital activities, exclusive of finances, containing brief hospital statistics and analyses of use, and presentations of the activities, needs and new objectives of most of the medical departments. The Stanford Clinics Auxiliary and San Francisco Maternity publishes a separate report of the work of the Social Service Department.

Mary's Help Hospital—Mary's Help Hospital, maintained by the Sisters of Charity for the care of the sick poor, was incorporated thirty years ago and is governed by a Board of Directors of six men which meets monthly. The board has a president and secretary, and reviews financial and statistical reports monthly, but functions without committees. The hospital has no national hospital association memberships, and publishes no annual report.

Board organization of this limited character is no longer advocated in Sisters' hospitals. Experience indicates that the interests of such hospitals are better served by a board composed of lay men and women, members of the Sisterhood conducting the hospital, and representatives of the Catho-

lic clergy. Boards thus constituted are in successful operation in other sections of the country, and have been found more effective in establishing close contacts with the community than the smaller boards consisting of men or Sisters only.

St. Mary's Hospital—St. Mary's Hospital, founded in 1855 to care for the sick, train nurses, and instruct students in medicine and surgery, is conducted by the Sisters of Mercy and governed by a board of four Sisters which meets monthly. The board has one committee, on finance, which also meets monthly and submits financial reports. As previously mentioned, this type of organization is less effective in meeting community health needs than the larger boards constituted as outlined. A women's auxiliary recently organized to assist with a dispensary department, which is in process of establishment, has as yet no definite functions.

The hospital is a member of the Catholic Hospital Association. No annual report has been published since 1920.

Mount Zion Hospital—Mount Zion Hospital, incorporated in 1847, primarily to serve the Jewish sick of the city, is governed by a Board of Directors of seventeen which meets monthly, has the usual officers and rather elaborate committee organizations, including Executive, Purchasing, Kitchen, Diet-Kitchen, Laundry, Linen room, Dispensary, Social Service, Finance, Pharmacy, Laboratory, X-ray, and Building and Grounds. Members of the Ladies' Auxiliary, an unofficial group active in hospital work, serve on many of the committees, in some instances constituting the entire committee personnel. Committees meet monthly and submit reports to the board through the Executive Committee. The committee organization suggests that committees participate in administrative activities. Neither the Committee on Nurses nor the Dispensary or Social Service Committees are organized along the lines considered appropriate for their respective responsibilities. An unusual committee is the Medical Conference Committee composed of members of the staff, department heads and board officers, which functions as a policy-making body in medical matters.

Members of the Ladies' Auxiliary also serve on many of the committees and as workers in the Social Service Department. The organization as a whole suggests considerable activity both on the part of the board and of the auxiliary. The institution has no national hospital association memberships. A brief report of its activities is contained in the annual report of the Federation of Jewish Charities.

St. Luke's Hospital—St. Luke's Hospital, founded in 1871 to care for the sick, is governed by a Board of Directors of nine men and two women which meets monthly and has, in addition to the usual board officers, a combined treasurer and auditor. The committees of the board are: Executive, Investment, Training School, Social Service, and Dispensary. Of the foregoing, the Executive Committee alone meets regularly. The other committees meet only on call, and do not include the personnel regarded as advisable for effective board contact with hospital matters. The board does not review the usual reports considered essential for the guidance of the governing body of a hospital. Lacking reports of work done and a com-

mittee organization, there appears to be insufficient contact with hospital affairs. The hospital is an institutional member of the American Hospital Association and publishes a report annually, which, among other matters, contains a complete financial statement and a less detailed statistical and medical report. An auxiliary committee, called the Women's Board, appears to function largely in rendering voluntary assistance.

Comment

So brief a summary of general policies does not depict the many individual excellencies of organization and direction which exist, nor does it convey a true impression of the instances of devoted and sympathetic interest which characterize so much of the hospital service.

It is by no means uncommon in hospital affairs to find that the personal attention, good-will, and generous interest of board members are hampered by poor organization, incomplete provisions for committee activities, and ineffective means for reviewing the results achieved.

An important development in the hospital world is that boards are finding it advisable to effect changes in types of directing organization which, though formerly satisfactory, are today unsuited to meet the demands of modern hospital operation.

The directing groups of the ten hospitals would gain by a critical self-analysis of the adequacy and suitability of their individual organizations for the administration of their respective trusts. It is clear that there is need for a greater familiarity with many principles of board organization, committee functions, public reports, etc., which are advocated by leading hospital boards, administrators, and national hospital associations.

It is proper that attention be directed to the fact that the three most prominent hospitals, both as to size and leadership—the San Francisco, University of California, and Lane and Stanford University Hospitals—lack boards so widely representative and thoroughly organized as to permit the type of intensive study and direction of these great public utilities which their complexity, cost, and importance demands.

SERVICES RENDERED BY HOSPITALS

In learning the extent of the community service rendered by a group of hospitals, we measure both individually and collectively, (a) the degree to which the facilities are used, (b) the hospital care given to full-pay, part-pay and free patient groups, (c) the medical services offered, and (d) the areas and the sections of the population served.

The facts herewith presented relating to these factors of service for the ten hospitals are based on the experience of 1921 and 1922, assembled by the institutions for the Survey, the data collected on June 21, when a census was taken of hospital patients, information collected at the hospitals, opinions and facts furnished by physicians and medical and social agencies, facts contained in published hospital reports, information collected by visits to 160 patients discharged during the first three weeks of June, and

an analysis of the places of residents of the 6542 patients admitted to the hospitals during two representative months—November, 1922, and January, 1923.

(a) EXTENT OF USE OF HOSPITAL BEDS

The unit of measurement of hospital use is the care of one bed patient for one day, the extent of use being indicated by the comparison of the number of days' treatment furnished in a given period, with the number of days' treatment available in the same period. For example, a hospital of 100 beds with 36,500 days available yearly, if actually furnishing 30,000 days, uses 82 per cent of its potential facilities.

Hospital authorities estimate, allowing for renovations, repair of wards, quarantine, and seasonal fluctuations in demand, that a general hospital should use an average of 75 per cent of its available days of care for a year as a whole, and that over 80 per cent of use should be expected during the busier portions of the year.

A degree of use of less than 75 per cent is commonly due to one or more factors, (a) overbuilding; that is, more hospital beds than are actually needed, (b) unsuitable distribution of facilities for the several patient groups, and (c) defective administration.

When an institution shows 85 per cent of use or more, it is generally taken as an index that the demand for beds exceeds the supply, and that the administration of the hospital is effective.

If each of the 2782 beds in the ten institutions was used every day of the year, they could furnish a total of 1,005,210 days of care, but such a performance would be impracticable in hospital administration and is unknown in the experience of general hospitals for acute sickness.

The percentage of use during the past two years for the institutions as a group, including the facilities for tuberculosis and acute communicable diseases, was:

Use of Hospital Facilities, Including Tuberculosis and Communicable Diseases

1921	68%	(685,778 days)
1922	71%	(714,659 days)

The exact percentage of use of the general hospital beds is not known, due to the fact that the San Francisco Hospital could not furnish the days of treatment of the general hospital section apart from these data for the 120 beds in the communicable disease department.

The degree of use of the general hospital facilities for the past two years, as given below, includes both the general and communicable disease experience. The percentage of use of the 913,960 days of treatment thus available was:

Use of Hospital Facilities, Tuberculosis Excluded

1921	67%	(608,434 days)
1922	69%	(629,567 days)

During 1922 the hospitals cared for 51,811 patients, as follows:

Hospital Admissions—1922

	Patients		
PUBLIC INSTITUTIONS—			
San Francisco Hospital	7993		
University of California Hospital	4726	12,719	(25%)
PRIVATELY CONTROLLED INSTITUTIONS—			
Children's Hospital	4873		
Franklin Hospital	3838		
French Hospital	2366		
Lane and Stanford University Hospital	8933		
Mary's Help Hospital	4071		
Mount Zion Hospital	4657		
St. Luke's Hospital	5960		
St. Mary's Hospital	4394	39,092	(75%)
Total		51,811	

The individual experience of the hospitals expressed in days of care, presented in the following table and in Chart A, page 43, indicates the total number of days of treatment available, the actual number of days of treatment furnished, and the percentage of use these facts represent, for each of the ten institutions.

Degree of Use of Hospitals—1922

	Total Days Bed Care Available	Total Days Bed Care Given	Per Cent of Use
PUBLIC INSTITUTIONS—			
San Francisco	234,695	158,027	67
University of California	92,710	61,049	66
Total	327,405	219,076	67
PRIVATELY CONTROLLED INSTITUTIONS—			
Children's	100,375	60,128	60
Franklin	78,110	54,813	70
French	73,000	46,663	64
Lane and Stanford University	114,610	79,138	69
Mary's Help	53,655	34,379	64
Mount Zion	54,750	44,147	81
St. Luke's	51,465	39,457	76
St. Mary's	60,590	51,766	85
Total	586,555	410,491	69
Grand Total	913,960	629,567	69

As shown in the foregoing table, neither of the two tax-supported hospitals, and but three of those receiving voluntary contributions—St. Mary's, Mount Zion, and St. Luke's Hospitals—attained 75 per cent or more of use; the remaining five showing 60 to 70 per cent of use.

In order to ascertain the facts regarding possible periods of maximum and minimum demand for hospital care, a further detailed analysis was made of the percentage of use of the combined hospitals throughout a twelve-month period. The result of this analysis, showing the percentage of use by month for seven* hospitals is as follows:

Per Cent of Use of Combined Hospital Facilities by Month—1922 (Seven Hospitals)

	Per Cent of Use
January	69
February	71
March	71
April	69
May	65
June	67
July	67
August	67
September	64
October	68
November	68
December	68

Average for year, 69 per cent.

*The San Francisco, Mount Zion and St. Luke's Hospitals could not furnish these data.

DEGREE OF USE OF BEDS IN TEN HOSPITALS OF SAN FRANCISCO — 1922

	Days of Bed Care Available	Days of Bed Care Given	
Total	913,960	629,567	69%
St. Mary's	60,590	51,766	85%
Mount Zion	54,750	44,147	81%
St. Luke's	51,465	39,457	76%
Franklin	78,110	54,813	70%
Lane and Stanford University	114,610	79,130	69%
San Francisco	234,695	158,027	67%
University of California	92,710	61,049	66%
Mary's Help	53,655	34,379	64%
French	73,000	46,663	64%
Children's	100,375	60,128	60%

CHART A

This experience for the twelve-month period, also shown in Chart B, page 45, while based on but 40 per cent of the city's hospital facilities, presents so slight a seasonal variation that it is probable that the experience of the other institutions would be approximately the same. It is significant that in no month of the twelve-month period did the seven hospitals, as a group, show 75 per cent of use, the highest, 71 per cent, occurring in but two months, February and March, and the lowest, 64 per cent, in September.

The degree to which the individual hospitals used their available numbers of days throughout 1922 is shown in the following table, which thus indicates that, although as a group, the hospitals showed relatively slight variation in the extent to which the available number of days were used from month to month, there were considerable differences in the extent to which individual institutions were used throughout the year:

Degree of Use of Individual Hospitals by Month—1922 (Seven Hospitals)

	Children's	Franklin	French	Lane and Stanford Univer.	Mary's Help	St. Mary's	Univer. of Calif.
	Per ct.	Per ct.	Per ct.	Per ct.	Per ct.	Per ct.	Per ct.
January	64	72	64	72	60	81	68
February	64	77	65	73	86	79	59
March	61	69	72	77	61	89	55
April	62	65	67	64	77	81	77
May	59	65	67	68	61	73	66
June	55	71	64	67	75	73	59
July	59	75	62	68	59	73	73
August	62	71	58	68	71	69	68
September	58	72	60	69	57	72	57
October	80	78	58	71	57	78	64
November	61	72	63	69	54	77	77
December	69	66	65	71	57	81	64

Thus, the percentage of use at the University of California Hospital varied during the twelve-month period from 57 to 77 per cent. In only two months, April and November, did the institution use 75 per cent or more of its potential capacity, four months, March, February, June and September, showing but 55, 57 and 59 per cent of use.

The degree of use of the facilities at Lane and Stanford University Hospital showed somewhat less variation, with a minimum percentage of 64 per cent in April, and a maximum of 77 per cent in March.

The French Hospital facilities showed fluctuations in use from 58 to 72 per cent, in no month attaining 75 per cent of use.

The percentage of use at Mary's Help Hospital showed the widest variations of any of the institutions, with a maximum of 86 per cent during February and a minimum of 54 per cent during November, and with three of the months—February, June, and April—showing 75 per cent or more of use.

The Franklin Hospital shows a fairly constant use, three months—

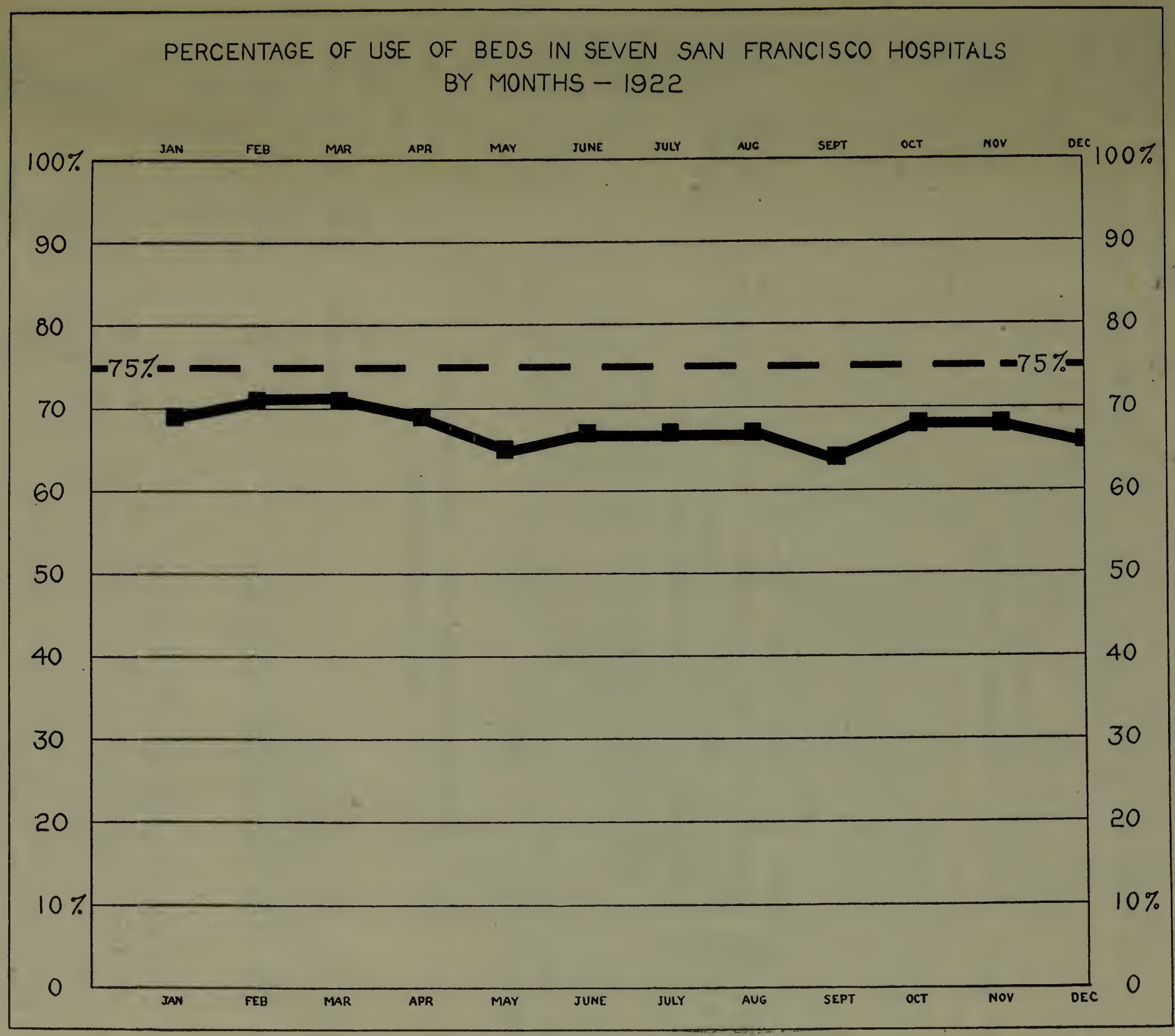

PERCENTAGE OF USE OF BEDS IN SEVEN SAN FRANCISCO HOSPITALS
BY MONTHS – 1922
JAN
FEB
MAR
APR
MAY
JUNE
JULY
AUG
SEPT
OCT
NOV
DEC
100%
90
80
75%
70
60
50
40
30
20
10%
0

CHART B

February, July, and October—showing 75 per cent or more of use, with the lowest percentage occurring in April and May, when 65 per cent of the facilities were used.

St. Mary's Hospital shows a general percentage of over 75 per cent of use and for four months, over 80 per cent. During March, the hospital was used to 89 per cent of its capacity, the highest percentage for any one month for any of the seven institutions. The lowest percentage, 69 per cent in August, was also the highest minimum for any of the hospitals.

The Children's Hospital shows a fairly constant use of from 55 to 64 per cent. While a children's hospital may show a generally low degree of use because of the emergencies, such as contagion, arising in their operation which require that facilities be available when needed, although such a need may be infrequent, analysis of the very complete statistics assembled by this institution did not indicate that such was the case in this instance. The department for communicable diseases during 1922 used 22 per cent of its available days, the general hospital sections, minus the foregoing, showing but 64 per cent of use. Further analysis of the days of care furnished to special patient groups reflect a generally low use of the available capacity. Thus, the maternity department, with 12,410 days available, in 1922 was used to but 59 per cent of its capacity.

It is of interest that on June 21, on which day a census was taken of the patients in each hospital, 1805 of the beds available, exclusive of those for tuberculosis at the San Francisco Hospital, were in use. As shown in the following table, the percentages of use on this day do not differ markedly from those for 1922 as a whole:

***Percentage of Use of Hospitals—June 21, 1923**
(Including Contagion)

	Number Patients	Number Beds	Per Cent of Use
PUBLIC INSTITUTIONS—			
San Francisco Hospital	428	643	69
University of California Hospital	149	282	59
Totals	577	925	62
PRIVATELY CONTROLLED INSTITUTIONS—			
Children's Hospital	194	275	79
Franklin Hospital	141	214	66
French Hospital	130	200	65
Lane and Stanford University Hospital	252	314	80
Mary's Help Hospital	123	147	84
Mount Zion Hospital	118	150	79
St. Luke's Hospital	119	141	84
St. Mary's Hospital	151	166	89
Totals	1228	1607	70
Grand Totals	1805	2532	71

*New-born infants and cribs for new-born are not included in estimating percentages.

The extent to which the hospitals are used suggests that the accommodations represented in this group of institutions afford ample facilities for the hospitalization of their patients, with possibly the exception of St. Mary's Hospital. The percentage of use of this institution reflects a continuously high degree of use, and suggests a demand for additional facilities.

(b) SERVICES FURNISHED TO PATIENTS OF DIFFERENT ECONOMIC GROUPS

There are three standard classifications for grouping patients according to rate of payment; namely, full pay, those who pay the full cost of their care; part pay, or those who pay part of the cost of their care, and free, those who pay nothing for their care.

The total amount of free service rendered by a hospital is represented by a number of days for which no part of the cost was paid, plus the free service furnished to patients paying less than the cost of their care.

In ascertaining this total amount of free service, the free care to part-pay patients is determined in conjunction with the per capita per diem cost, and the difference between the amount paid and the cost translated into terms of days. Thus, a hospital with a per capita cost of $4 a day, giving 200 days of care at the rate of $3 a day, and 100 days of care at $2 a day receives $800 for service which actually cost $1200, furnishing free care to the amount of $400—the equivalent of 100 days of free care at the rate of $4 a day.

Due to the small extent to which consideration of per capita costs enter into the assembling of data regarding part-pay patients in the hospitals, the Survey was unable to determine the actual amount of free service thus rendered. In consequence, the number of free days' treatment includes only the service received by patients paying nothing for their care.

In addition, the material furnished the Survey indicated that in some instances part-pay patients, because they pay the rate charged, although it may be less than cost, are confused with pay patients. These facts should be borne in mind in interpreting the facts herewith presented regarding the economic groups served.

During 1922, of the total days of treatment furnished by all ten hospitals, 54 per cent were paid for in full, 12 per cent were partly paid for, and 34 per cent were free. These facts for the individual hospitals are shown in the following table and in Chart C, page 49.

Full Pay, Part Pay and Free Care, by Hospital—1922

	Total Days of Care	No. Full Pay Days	Per Cent	No. Part Pay Days	Per Cent	No. Free Days	Per Cent
PUBLIC INSTITUTIONS—							
San Francisco	158,027	.....	..	.....	..	158,027	100
University of California	61,049	21,127	34	19,961	33	19,961	133
Totals	219,076	21,127	10	19,961	9	177,988	81
PRIVATELY CONTROLLED INSTITUTIONS—							
Children's	60,128	33,977	65	7,780	13	13,391	22
Franklin	54,813	52,343	95	.....	..	2,470	5
French	46,663	46,560	99	.....	..	103	1
Lane and Stanford University	79,138	43,299	55	33,949	43	1,890	2
Mary's Help	34,379	29,946	87	1,975	6	2,458	7
Mount Zion	44,147	25,152	57	8,250	19	10,745	24
St. Luke's	39,457	37,029	94	864	2	1,564	4
St. Mary's	51,766	43,934	85	4,759	9	3,973	6
Totals	410,491	317,220	77	57,577	14	35,694	9
Grand Totals	629,567	338,347	54	77,538	12	213,682	34

Of the two public institutions, the San Francisco Hospital furnishes free care to all patients, with the exception of a few paying patients admitted to the communicable disease department. The University of California Hospital does not assemble facts which would indicate the service which was free to patients, but estimated that one-half of the total days of care, other than full pay, were furnished without cost and the remaining half were paid for in part, the cost of maintenance of patients paying nothing, or in part, for their hospital care, being met by State funds.

Of the eight privately controlled institutions, Mount Zion Hospital and the Children's Hospital gave over 20 per cent of free service, the remaining institutions, Mary's Help, Franklin, French, and Lane and Stanford University Hospitals furnishing 6 per cent or less of their services free.

The information furnished by the Franklin Hospital, showing 79 per cent of full pay and 17 per cent of part pay service, was not used as the 9149 part pay days which were given during the year were furnished to members of the German General Benevolent Society, and for this the hospital received $56,870.95 from the Society. These 9149 days, therefore, are included with the institution's full pay days.

Likewise, the information furnished by the French Hospital, showing 28 per cent full pay, 23 per cent part pay, and 49 per cent free service, was not used. The official report of the French Mutual Benevolent Society indicates that the total hospital service, with the exception of 103 free days of care, was furnished to full-pay private patients or members of the Society. The 10,696 part pay days and 23,202 of the 23,305 free days, therefore, were fully paid for and are thus classified by the Survey.

The combined data regarding the economic groups cared for, point to

PERCENTAGE OF DAYS OF TREATMENT TO FREE, PART PAY AND FULL PAY PATIENTS IN TEN SAN FRANCISCO HOSPITALS — 1922

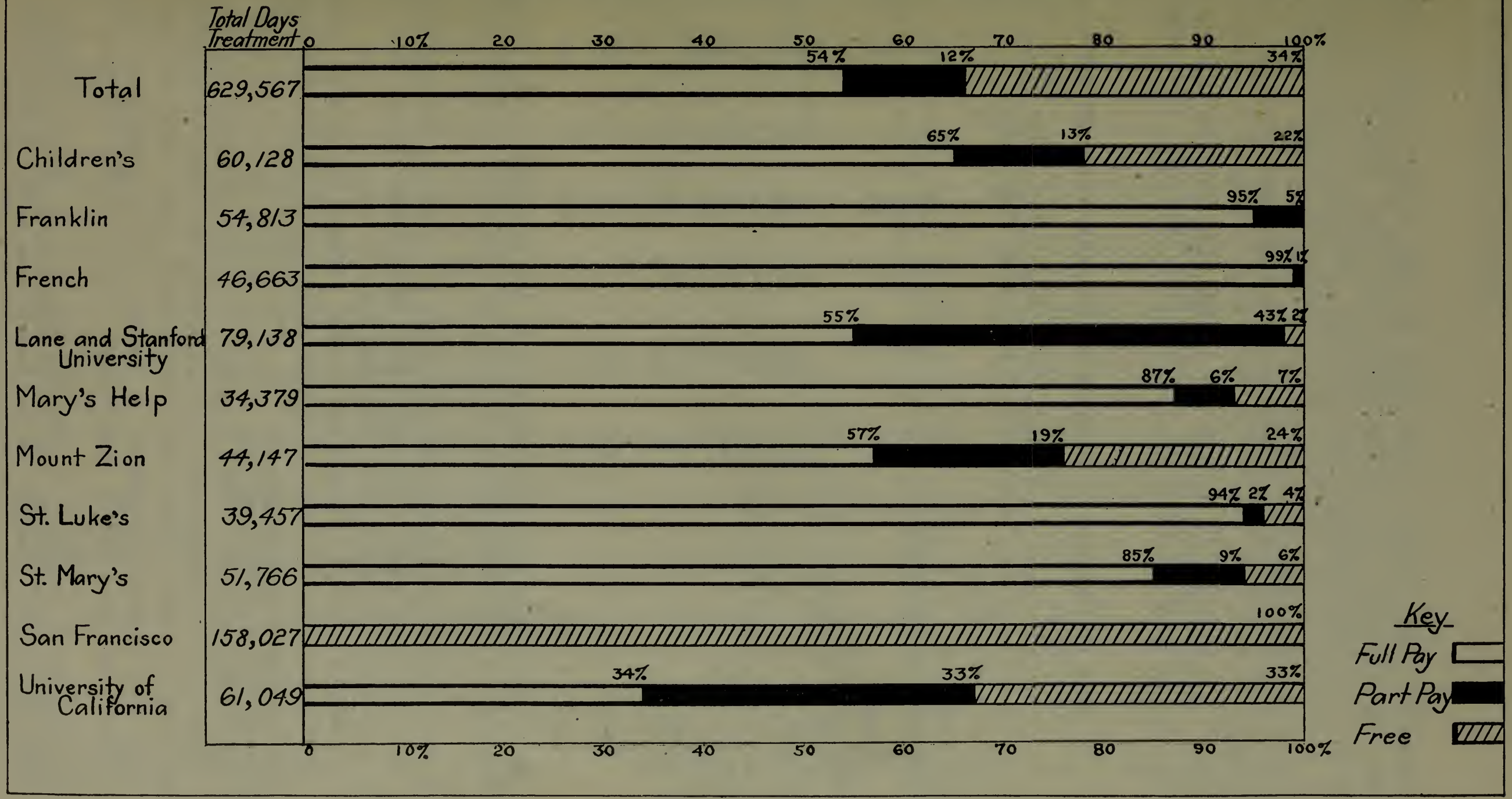


CHART C

the conclusion that, with 77 per cent of the service given to full-pay patients, the facilities of the privately controlled hospitals are devoted mainly to this patient group; that, with the exception of the generous free service furnished at the Children's and Mount Zion Hospitals, only a small amount of service is given without cost to patients—but 9 per cent; and that the service to patients paying in part for their care is relatively small—14 per cent.

These conclusions are borne out by the analysis of the rates being paid by the patients in nine* of the hospitals on June 21, shown in the following table:

Rate of Payment of Patients in Hospitals—June 21, 1922

	Totals (100%)	Full Pay	Per Cent	Part Pay	Per Cent	Free	Per Cent
PUBLIC INSTITUTIONS—							
San Francisco	428	...	..	..	..	428	100
University of California	149	56	38	40	26	53	36
Totals	577	56	10	40	7	481	83
PRIVATELY CONTROLLED INSTITUTIONS—							
Children's	194	120	62	36	19	38	19
Franklin	141	101	72	38	27	2	1
Lane and Stanford University	252	230	91	9	4	13	5
Mary's Help	123	97	79	15	12	11	9
Mount Zion	118	70	59	23	20	25	21
St. Luke's	119	115	97	..	..	4	3
St. Mary's	151	130	86	12	8	9	6
Totals	1098	863	78	133	11	102	9
Grand Totals	1675	919	55	173	10	583	35

One of the important developments in the hospital world is the growing demand by self-supporting families of moderate means for hospital care.

This is shown by the demand for beds in small wards accommodating from two to six persons, a demand which has increased markedly throughout the country during the past few years.

In hospital operation, analyses of the volume of service rendered to the various economic groups and the type of facilities demanded, are increasingly used by hospital boards and administrators as a basis for determining the character of the provision which must be made to meet community requirements. For example, a hospital board presented with facts showing that certain large private rooms are used to but 50 per cent of their capacity while wards and semi-private wards show 80 per cent of use would be inclined to convert a portion of the rooms to semi-private uses. Again, analyses of the percentage of use of the rooms of different

*The information furnished in this particular by the French Hospital was not used, as it indicated that 37 per cent of the patients were free, nine having been in the hospital over a year. As only 103 free days of care were furnished during the last year, it was suspected that the information sought was not understood.

prices might indicate a low use of high-priced rooms and a high use of moderately priced rooms. Presented with such facts, a board would naturally request data covering a definite period regarding the number of part-pay patients applying who could not be accommodated, in order to have an accurate basis for action.

With the exception of Lane and Stanford University, none of the hospitals furnished information which indicates that such analyses are made and no studies have been made which would show the extent of the demand for part-pay facilities either individually or collectively. There is, however, a general sentiment among hospital administrators that increased provisions for part-pay patients are urgently needed.

It must be apparent that the breadth of the hospital service which these ten institutions make available for the community is reflected in part, in the nature of the provisions for the different economic groups, as they determine to a great extent the portion of the sick of the community which the hospitals serve.

The free hospital beds of the city are the 896 beds at the San Francisco Hospital and the endowed beds at the privately controlled hospitals, as follows:

	Free and Endowed Beds
San Francisco	896
Children's	28
St. Luke's	5
French	5
St. Mary's	6
Franklin	4
Lane and Stanford	None
University of California	None
Mount Zion	50
Mary's Help	2
	996

Comparison of the available free days of care represented in the free beds at the privately controlled hospitals and the free service given during 1922, indicates that most of the hospitals provide free service exclusive of that free service to part-pay patients, far in excess of the amount which could be given if the designated free beds alone were used for this purpose. The chief exception to this fact was Mount Zion Hospital, at which the part-pay service constituted 19 per cent of the service for the year, a percentage of part-pay days of care only exceeded by the two university hospitals.

	Number of Days' Care Available in Endowed Beds	Number of Entirely Free Days of Care Furnished During 1922
Children's	10,220	12,390
Franklin	1,460	2,202
French	No data	103
Lane and Stanford	None	1,890
Mary's Help	730	2,458
Mount Zion	18,250	10,745
St. Luke's	2,920	1,564
St. Mary's	2,190	3,073

It is clear, however, that neither the free service at these hospitals and the San Francisco Hospital, nor the part-pay facilities generally meet current needs, as the information furnished the Survey indicates that the difficulty experienced by physicians and organized social groups in hospitalizing free patients and those paying moderate rates, is no minor matter. The opinions of the members of the San Francisco County Medical Society on this subject are highly important, and reflect conditions that certainly deserve special consideration. Individual replies from physicians stated:

"There is a serious need for a hospital for patients who are not charity cases, but who cannot pay from $6 to $7 a day and up in our private hospitals."

"It has been my experience that the very poor people of this city are better taken care of than any other class. The need is for some system whereby the man earning a salary of from $150 to $200 per month can get medical care without going to a free clinic, and thus being pauperized."

"More beds are needed for the man who can pay $10 a week. It costs too much to be sick. There is nothing new in this statement, and though I have given it much thought, I can see no way to lower the cost with fairness to all."

"There is undoubtedly a need for more beds at more moderate rates for wage-earners. I find great difficulty in hospitalizing medical patients, due to the great expense of hospital beds."

"Hospital beds are needed for free and part-pay patients. There is everlasting red tape to be cut before I can get real assistance for medical patients."

"There are too many boarders in hospitals and too few free beds."

"I firmly believe that the services dealing with the preservation of disease and the treatment of the indigent are exceedingly well covered. The time must come, however, when those in moderate circumstances should be placed in a position where they can buy and pay for medical attention. Private or special nursing still needs adjustment."

The following are the more important and commonly held opinions expressed by the social agencies:

"As far as my knowledge goes, we have the best hospital care that I have known in the entire United States. I do feel this: that the San Francisco Hospital should have a ward or wards where people could pay a fair sum of money for medical care—$30 or $35 per month, instead of the high and almost prohibitive prices of hospitals for the working class, or the medium class of people, financially. It is almost impossible for the average wage-earner to pay the prices charged where they are required to go to wards or to special rooms in the various hospitals. Some law should be enacted giving the city and county the right to proceed criminally or civilly, or both, against relatives who are in a position to pay."

"There is undoubtedly need for more free service at both the University hospitals. It is difficult to get the best work from the physicians who are giving volunteer service in the clinics if they cannot keep their patients in their own hospitals when such care is needed. If the patient is placed in the same hospital, the clinician can keep in close touch with his patient through the courtesy of the staff physicians, even when he must transfer the actual medical care to another physician."

"There is a crying need for a department for part-pay patients. The problem presents itself time and again as patients have to be sent home from hospitals too soon after severe operations and illnesses because they cannot afford to stay as long as needed."

"It is practically impossible for the unskilled and the semi-skilled, and even

the skilled, to meet the cost of a long illness if they are unwilling to avail themselves of the free clinics or to ask for free care at the San Francisco Hospital, or if they are not in a somewhat personal relationship to a family physician who will make special rates for them. For this reason, it is certain that there is a great need for greater hospital facilities at rates far lower than those now charged for ward beds.

"At the San Francisco Hospital there are still empty wards available. If these wards are not to be needed in the near future for patients who cannot pay at all, would it be advisable to establish in the San Francisco Hospital the policy of taking patients who could pay small amounts. If the policy is the right one, the legal difficulty can easily be overcome by getting the Supervisors at regular intervals to reappropriate to the hospital the money that has been paid in to the city's general fund. The establishment of this system would probably net a substantial income to the city, which might be used to supply the additional nursing service so much needed. Probably many patients are accepted today as free patients who could afford to pay a reasonable amount, but could not pay the amount charged in the existing hospitals for ward service. The establishment of such a policy might be a mistake if the need for free beds was in the near future apt to grow to the extent of demanding all the space in the City Hospital. This question of policy must, of course, be determined by the hospital expert."

The physicians' reactions to inquiry as to the adequacy of hospital facilities indicate dissatisfaction with the delays and obstacles connected with the admission of patients to the San Francisco Hospital. To quote:

"There is unnecessary delay in admitting patients to the Detention Hospital. At times this is also true regarding admission to the San Francisco Hospital of serious cases demanding early attention, and of the Isolation Hospital."

"I have had difficulty in obtaining bed care at the San Francisco Hospital for destitute surgical cases."

"It is difficult to get hospital care for medical cases. The City and County Hospital is seldom available at short notice for medical cases. I have not infrequently been informed by patients who are able to pay for care, that they have succeeded in getting free care, both at the San Francisco Hospital and at clinics. On the other hand, I have known needy patients to be kept waiting for an opportunity to enter the San Francisco Hospital."

"It has been my experience that it requires all kinds of references to get a patient in the San Francisco Hospital."

"The City and County is very good when they have the room. If they could transfer some of the 'old chronics' to some other place to make room for the acute sick it would be a help. Sometimes we have been obliged to wait three or four days to get a 'worthy' patient into this hospital."

The demand for free hospital beds is greatest during the winter months, partly due to the climatic conditions and partly due to the fact that men from the farms, fisheries and lumber camps come to the city during the winter. The need of hospitalization of these and other groups of non-resident sick who cannot pay for care and yet are not legitimate charges upon the city, creates a situation which, in the opinion of members of the medical profession and social workers, demands attention. To quote some of the opinions expressed:

"The patient we have the most difficulty taking care of is the man without funds who comes in from out of town. He is not eligible to a bed at the San Francisco Hospital, and often needs hospital care or possibly operation. Our social service workers work hard and do all that can be done, but there are not

enough funds available to provide for many of these fellows who are in need of the care."

"More free beds are needed, especially for non-residents of the city and of the State. The transient population offers a large problem in California—the financial aspect is not the least important. May I suggest that the charities of the country establish a service similar to the clearing-house of the banks? Through such an institution the transient sick poor could be treated in the city of their new residence and be supported by the charities of their home cities."

"The chief difficulty I have encountered has been the cases of indigent sick who have not been in San Francisco for the required length of time to qualify for the San Francisco Hospital. If a man drops in the street the Central Emergency Service must look after him, but as long as he can drag himself around there is no place for him."

"More free beds are needed for patients not eligible to the San Francisco Hospital. I have difficulty in regard to the patient from outside the county who has no funds and who needs surgical treatment not available in his own county."

It must be obvious that, collectively, these opinions indicate that there are unsolved problems of importance to the city's sick and to the progress of medical care and medical education in San Francisco. The community is fortunate in having within its midst such a wealth of interest and individual appreciation of the desirable elements of community health service, for they constitute a nucleus for fair and unhurried study of the subjects here presented.

(c) MEDICAL SERVICES MAINTAINED

All of the ten hospitals receive patients with general medical and surgical conditions, and maternity patients. But two of the institutions, the San Francisco and Children's Hospitals, receive patients suffering from acute communicable diseases. One, the Lane and Stanford University Hospital, receives patients with mental and neurological conditions. None of the hosptials, with the exception of the San Francisco Hospital, receive patients with venereal diseases or with active pulmonary tuberculosis.

The chief fact indicated by the foregoing limitations of service are the restrictive policies regarding neurological conditions, tuberculosis, and venereal diseases in the private hospitals, discussed in Section II.

As mentioned earlier in this section, the ten hospitals, as a group, provide all the accommodations in the city for acute communicable diseases and tuberculosis, and 94 per cent of the beds definitely set aside for the care of particular conditions.

Exclusive of the 250 beds for tuberculosis at the San Francisco Hospital and the 146 beds for acute communicable diseases at the San Francisco and Children's Hospitals, the beds assigned to the various medical services in the ten hospitals are as follows:

Beds Assigned to Various Medical Services

	Beds
Medicine—	
General Medicine	320
Pediatrics (including 114 for new-born)	249
Skin	2
Neurology	16
Venereal	75
Surgery—	
General Surgery	304
Gynecology	43
Genito-Urinary	6
Orthopedics	48
Eye	2
Ear, Nose and Throat	2
Obstetrics	148
Used Interchangeably	1135
Total	2386

Grouped according to the four main services, as below, the number of beds for medicine exceeds that for surgery, although this is not the case if the 75 beds for venereal diseases at the San Francisco Hospital are excluded from the first-named group:

Medicine	433
Surgery	405
Obstetrics	184
Pediatric	249
Used Interchangeably	1135
	2386

It is generally felt that there should be as many beds available for medicine and the medical specialties as for surgery and the surgical specialties, but the facts collected do not indicate that this is the case in this group of hospitals. The high proportion of the beds provided for surgery is further emphasized by the fact that a large percentage of the beds not definitely assigned and used interchangeably in the ten hospitals, and a still larger percentage of the beds in the nine hospitals of the city not included in this Survey are, as a matter of experience, used for surgical conditions.

The facts collected on June 21 indicate the ratio of the medical, surgical and obstetrical patients in the individual hospitals on one day:

Percentage of Medical, Surgical and Obstetrical Patients in Hospitals—June 21, 1923

	Medical Per cent	Surgical Per cent	Obstetrical Per cent
PUBLIC INSTITUTIONS—			
San Francisco (including Contagion)	52	42	6
University of California	36	50	14
Total	48	43	8
PRIVATELY CONTROLLED INSTITUTIONS—			
Children's	34	54	12
Franklin	33	61	6
French	38	53	9
Lane and Stanford University	37	56	7
Mary's Help	32	57	11
Mount Zion	33	55	9
St. Luke's	26	65	10
St. Mary's	31	51	9
Total	33	56	9
Grand Total	37	52	9

A further analysis of the census day data, showing the number of patients under the supervision of the various medical services at the different hospitals, is given in the following table:

	Public Institutions			Privately Controlled Institutions									
	San Francisco	Univ. of California	Total	Children's	Franklin	French	Lane and Stanford	Mary's Help	Mount Zion	St. Luke's	St. Mary's	Total	Totals
General Medical	133	33	166	36	47	49	67	39	31	31	47	347	513
General Surgical	146	67	213	62	86	43	111	70	57	77	77	583	796
Obstetrical	24	22	46	21	8	12	19	114	15	11	14	114	160
Pediatric	..	20	20	19	..	..	12	..	3	..	..	34	54
Orthopedic	11	..	11	44	..	..	5	..	..	..	..	49	60
Neurological	8	..	8	1	..	..	14	..	..	..	..	15	23
Ear, Nose and Throat	1	..	1	..	..	11	8	..	4	..	..	23	24
Eye	..	..	..	..	..	..	1	..	5	..	..	6	6
Genito-Urinary	3	..	3	..	..	9	3	..	2	..	..	14	17
Gynecological	17	7	24	..	..	6	10	..	1	..	..	17	41
Venereal	13	..	13	..	..	..	..	..	..	..	..	..	13
Drug	5	..	5	..	..	..	..	..	..	..	..	..	5
Communicable	64	..	64	11	..	..	..	..	..	..	..	11	75
Dental	..	..	..	..	..	..	1	..	..	..	..	1	1
Not stated	3	..	3	..	..	..	1	..	..	..	13	14	17
Totals	428	149	577	194	141	130	252	123	118	119	151	1228	1805

Although the foregoing facts present the experience of but one day and, therefore, cannot be taken as conclusive, they indicate to some degree the type of medical conditions hospitalized in the several institutions. At some of the hospitals the patients under the supervision of the subsidiary medical and surgical services were not so classified as to permit such an analysis. At four of the hospitals, the Franklin, St. Mary's, Mary's Help, and St. Luke's Hospitals, the patients were classified only under the three main patient groups—medical, surgical, and obstetrical. At the University of California Hospital, in addition to the foregoing classifications, pediatric and gynecological patients were separately indicated. At the French Hospital, eye, ear, nose and throat, genito-urinary and gynecological classifications were used. At the Children's Hospital, in addition to the medical, surgical, and obstetrical, pediatric and communicable diseases classifications, orthopedic and neurological patients were separately grouped. At San Francisco, Lane and Stanford University, and Mount Zion Hospitals the classifications, according to major subdivisions of medical service, were more precise and numerous than in the other hospitals.

The experience of San Francisco with the hospital isolation of the common communicable diseases of childhood is interesting because of its general similarity to that of other cities of the country of 500,000 population and over:

	San Francisco, June, 1922–May, 1923				Per cent Hospitalized in Cities of United States of 500,000 Population or over 1920
	Cases Reported to Health Department	Deaths Reported	Patients Hospitalized San Francisco and Children's Hospitals	Per cent Hospitalized	
Diphtheria	1265	108	429	33.9	24.3
Scarlet Fever	630	8	171	27.1	25.3
Measles	781	8	61	7.8	3.1
Whooping Cough	568	28	44	7.7	2.1

Apparently San Francisco hospitalized a higher percentage of patients with these diseases than is the case generally in other large cities, but the difference in the practice of communities in reporting diseases must be taken into account before accepting this table as showing an entirely correct comparison between the per cent hospitalized in San Francisco and that in other cities.

The number of days' care furnished to the various patient groups—the true basis for determining the relative amount of hospital service devoted to the various medical services—is not known, due to the fact that but three of the hospitals, the Children's, Franklin, and University of California Hospitals, assemble these important data. The percentage of services furnished at these three hospitals during 1922, grouped according to medical service were:

	Medical Per cent	Pediatric Per cent	Surgical Per cent	Obstetrical Per cent
Children's	6	67	14	12
Franklin	21	..	72	8
University of California	25	14	42	14

It is unusual to find a group of hospitals accumulating and assembling so little information for their own use or for the public, regarding the character and amount of service which is furnished the various patient groups. The methods of assembling and analyzing facts used in the leading hospitals of the country have not yet been adopted. Thus, many hospital executives review monthly the percentage of use of the beds assigned to the different services, for the information of their boards and attending staffs. For example, a hospital with the beds assigned to neurology showing a high degree of use and with those assigned to dermatology, gastro-enterology, etc., showing low percentages of use, has problems related to service for the sick and to intern and nursing education which can be intelligently acted upon. Is the low use of certain beds due to too liberal assignments to these specialties or to the conduct of these services, in either the hospital or the dispensary? What are the causes for increased demand for beds in one service and decreased demand for another service? For what percentages of these special groups is bed care needed to meet the sickness demand of the community? What must the range of cases include to furnish interns and student nurses with a comprehensive experience in the particular disease groups?

With the exception of the data furnished by the Children's Hospital, no facts were available which permit of even brief analysis of the various medical groups served. As the data collected by this one hospital are not analyzed with reference to the extent to which its facilities are used or to the sickness needs of the community, their chief value is lost.

The combined medical opinion on the subject of hospital accommodation suggests a general need for increased beds for general medical conditions, with special emphasis upon the needs of mental and neurological patients, the inadequacy of the accommodations for children and for patients suffering from eye conditions and venereal diseases. To quote:

"There is no way of keeping under observation or treatment acute and border-line mental patients. No systematic psychiatric work is being done that I know of."

"Service for mental cases, and especially acute delirious cases, is extremely poor. No hospital will keep them. They receive wholly inadquate care at the Detention Hospital and are sent to Napa. Private hospital facilities for psychiatric patients should be available at the San Francisco Hospital."

"I have great difficulty in obtaining free beds for nervous and mental patients. There are beds available at $3 a day to take care of the patients who can pay this fee, but funds for free beds are very limited. More beds are needed at the San Francisco Hospital for free mental patients."

"I would call your attention to the utter lack of any provision for patients with the milder forms of mental diseases. There is no space where a clinic patient can be placed for observation and care. He must be left an out-patient or be committed to the State Hospital. There is also a great need of a similar place for patients of moderate means. The minimum rate of privately owned institutions is $35 a week."

"There are no adequate means of caring for private or clinic patients with mental disturbances. A psychiatric hospital—a ward at San Francisco Hospital or at the University of California Hospital would be an immeasurable boon to

the community—there being absolutely no means in the city adequate to the needs of mental cases."

"I can find no place in San Francisco for free or part-pay care of open tuberculosis in young children."

"In the question of treating an individual with tuberculosis as matters now stand only the advanced cases can get hospital care, and naturally prognosis is poor. The early case is the one on which attention should be focused and bed care provided in a hospital if good results are to be obtained instead of treating them as now treated—ambulatory cases at out-patient departments."

"There is a great need of an extra-urban tuberculosis hospital."

"The chief necessities in tuberculosis work are—a sanitarium for ambulatory and semi-ambulatory groups, and increased nursing and trained professional supervisory staffs."

"I have difficulty in hospitalizing pulmonary tuberculosis cases that are unable to pay for sanatorium treatment."

"There is a crying need for taking care of malignancy along modern lines. I have great difficulty in handling patients with malignant diseases who need, but cannot afford to pay for the cost of Roentgen therapy."

"San Francisco has poor provisions for contagious cases. I find there is little done systematically for heart cases."

"The facilities for venereal patients are inadequate. The San Francisco Hospital will take such patients, but the other hospitals will only take such cases in private rooms, which usually means that, as a rule, a patient is not hospitalized as he cannot pay the price. As a result, they are a menace in the home or in public places, such as hotels, rooming-houses, etc."

The foregoing opinions and similar data presented earlier in this report, point to the difficulties experienced in obtaining hospital care for patients with limited means, suffering from particular illnesses.

An analysis was made of the information* collected on the census day, relative to the number of medical, surgical, and obstetrical patients which were full pay, part pay or free, with the following result:

	Full Pay Per cent	Part Pay Per cent	Free Per cent	Total Per cent
Medical	44	9	47	100
Surgical	61	11	28	100
Obstetrical	69	9	22	100
(Not stated)	82	..	18	100

These percentages indicate that on the day in question approximately one-half of the medical patients were free, something less than one-half paid fully for their care, 9 per cent being part pay. Of the surgical patients only 60 per cent were full pay, less than 30 per cent free, and 11 per cent part pay. Of the obstetrical patients practically 70 per cent were full pay, a little over 20 per cent free, and 9 per cent part pay. The striking facts are the small extent to which the part-pay patients in any of the three groups were hospitalized, the high percentage of full pay surgical and obstetrical patients, and the large percentage of free medical patients.

As similar analyses for the hospitals as a group could not be made,

*Exclusive of the patients at the French Hospital.

due to the lack of the facts for such a study, it is not known whether this experience on the census day represents the usual conditions. To be of value and to serve as a basis for so important a matter as rate-setting and redistribution of beds to medical services, comparable data, covering a number of months should be assembled by each hospital.

Inadequacies of Hospital and Medical Services

There are certain aspects of the services for the sick which received attention from the medical profession in replies to inquiry from the Survey, and certain inadequacies of hospital and medical care revealed through study, which should be considered.

Specific conditions mentioned by physicians relate to various phases of the care of the sick of the community and, although not included in the matters receiving the attention of the Survey, are highly important. The following opinions call attention to conditions which relate to or hamper hospital medical service:

It is difficult to hospitalize pneumonia patients.
Night clinics are needed for women who work.
Reports to physicians from hospitals are unknown.
Provision for after care of drug addicts is inadequate.
Provisions available for the handicapped are inadequate.
Wet nurses are needed at all hospitals.
Dental work is limited to emergency treatments.
Facilities for the rehabilitation of cripples are needed.
There are too many boarders in hospitals.
Auxiliary diagnostic facilities are costly.
There is too little control of laboratories.
Laboratory fees are too high.
Salvarsan at cost can only be obtained with difficulty.
There are insufficient X-ray films at the City Hospital.

After Care

The after care of hospital patients is a responsibility of the medical staff and the determination of a program for after care is a medical matter which cannot properly be delegated to others.

The need for after care as reflected in the character and extent of instruction to patients prior to discharge and the provisions made for return to complete health, is one that is only partially met in the ten hospitals. Case after case visited during the course of the convalescent study of the Survey indicated this defect of medical care.

Although the majority of the hospitals maintain contact with certain types of cases following discharge—some of them providing nurse follow-up of special patient groups—after care is provided for relatively few patients.

In a large percentage of the 160 patients visited in their homes, contact with the medical staffs responsible for their care had ceased on dis-

charge, and no provision had been made for other subsequent medical or nursing supervision. This fact is illustrated by the following cases:

Case No. 1—A patient who had been operated upon in one of the hospitals, where she remained for four weeks, had a fecal fistula on discharge. Following her return home she had a severe hemorrhage, but as the hospital had no bed available, she went to another, where she remained five days, and was discharged unimproved with a diagnosis of carcinoma of the cervix and recto-vaginal fistula. When visited she was sick in bed, had no means of obtaining the nursing care demanded by her condition, and was in need of immediate hospital care. The hospital in which the patient had been for so long under treatment was using less than 60 per cent of its available beds at this time.

Case No. 2—A case in which continued medical supervision was needed was that of a patient who, when she came to San Francisco, was under treatment at one of the dispensaries for syphilis, but as the salvarsan made her sick, she only took a few treatments. About a year later, when pregnant, she went to another hospital for prenatal care, having regular urine examinations but no blood examination. Her baby lived four months, was always sick and was taken care of as a free patient in a third hospital. The patient, when visited, was recovering from an operation for appendicitis and was referred back to the first dispensary by the visitor for the Survey for examination and treatment of her syphilitic condition.

Case No. 3—This patient, a child of two years, who had been removed from the hospital against the advice of the staff physician, but whose condition was sufficiently serious to require special attention even under the foregoing circumstances, had fallen from a second story window to the sidewalk, probably striking his head, as blood ran from his nose and ears and as he was unconscious for seven days. On leaving the hospital, one ear was discharging pus, and the mother was told by the doctor that the child should continue under medical supervision and to take him to a public dispensary, distant from her home. Although she stated she was keeping a boarding-house and could not go so far, she was not told that she lived only a few blocks from another dispensary.

When visited, the child's ear was still discharging pus. As the doctor at the hospital told the mother to irrigate the ear, but had not told her what to use, she had been irrigating the ear with lysol solution as strong as the child could stand.

Not only was this patient in need of home nursing care and dispensary care, but, due to the poor instructions the mother received, he was having treatments which were seriously unsuitable, if not dangerous.

Case No. 4—This case, indicating a need for persistent follow-up, was a child of five with club feet, who had been a free patient in the hospital for a month. When much younger he had been under treatment and wore a cast, but because of the expense his parents had neglected to keep up with the treatments, so the work had to be done all over again. While in the hospital, the child had had an operation and a cast applied on one leg, and was shortly to return to have similar treatment for the other leg. The home was exceedingly dirty, the mother ignorant, and the instructions given her had not been understood. It should have been obvious, in dealing with the case the second time, that favorable end-results depended on special supervision and instructions, but there was no indication that the seriousness of the situation had been made clear to the parents.

We have only to contrast the foregoing and other cases cited later in this section, with the following instance of excellent follow-up and after care, to point out the results which are possible when there is a program for further care, and when sufficient workers for follow-up are available:

Case No. 5—The patient, a three-year-old child with one leg shorter than

the other due to congenital syphilis, had been in the hospital for only a short period for observation and treatment, but had been for many months under the supervision of the out-patient department. The parents had been fully instructed at the clinic regarding the child's condition, treatments, etc., and follow-up visits had been made to the home by the hospital's social service department, so that every precaution was being taken to secure favorable results. The parents knew the character of the treatments, that they would have to be continued for many months, and that everything was being done that the hospital could do.

This case is illustrative of the many cases visited in which the follow-up was effective and in which careful instruction had been given by the physician or surgeon responsible for the case.

The picture presented by those patients who sought the instruction and medical direction which should have been provided as part of their medical care without effort on their part, is a serious one:

Case No. 6—A little boy of eight, who had been in the hospital over two months with a fractured femur, was discharged to his mother with insufficient instruction. As his right leg was in a cast from the hip to the ankle, she asked the nurse in charge of the ward how to care for him. The nurse declined to give any advice and referred her to the doctor. The mother had to hunt him up herself and found him in a room doing a dressing. The only instructions he gave her were to take the child to a public dispensary. The boy was kept in bed for a week after returning home and was then allowed to use his leg. After ten days the mother telephoned the same doctor at the hospital and asked him when she should take the boy to the clinic and what she should tell them there. When it was understood that the boy had been permitted to walk, the mother was told to keep him off his feet for a week and then to bring him back to the hospital, because the doctor was afraid the bone might not have united completely, as it had been used too soon.

Case No. 7—Another case, a little girl of six in the hospital two days following a tonsillectomy, was brought home in an ambulance. The mother had received no instructions regarding the after care of the child, so, as the patient was suffering, she took her back to the hospital, four days after discharge, to find out what should be done.

Case No. 8—A woman who had been in the hospital for two weeks with neuralgia, arteriosclerosis and hypertension was given no instructions on discharge, nor referred to any dispensary for follow-up. As the patient felt ill and weak after leaving the hospital, she went back to see the doctor who had cared for her, but she was unable to talk with him because he was busy. She then went to the ward and asked the nurse in charge if she could make arrangements to see the doctor. The nurse was new and did not know the patient, so she was apparently not much interested and said the doctor might come in any minute or he might not come in at all.

The needs of a large number of patients would have been met by reference to a dispensary where they could have obtained the needed medical supervision. To cite a few of those showing the more serious needs:

Case No. 9—A man of 50, in the hospital almost two months because of a fractured leg, was given no instruction on discharge from the hospital, or the name of any dispensary where he might go for medical supervision or needed physiotherapy. His leg was still very stiff from the cast and the patient was worried about his slow improvement. He was in need of advice as to where he could obtain the needed medical care, special treatment, and medical opinion regarding the condition of his leg.

Case No. 10—A little girl of five, in the hospital for sixteen days with tonsillitis, was discharged to her mother without instructions as to her further care.

The mother did not speak English and may have misunderstood directions, but she knew of no place to go for free instruction for the feeding and care of either this child or of her ten months' old baby. A physician had made all arrangements for her at the hospital where she paid $2.50 a day, but she could not afford the expense of a private physician for further medical care.

Case No. 11—A homeless man of 36, in the hospital for almost two months with acute arthritis, when discharged went to a rooming-house. He was without money and was being suported by friends who felt sorry for him, giving him 25 cents a day for his meals. Some days he had one meal and some days three meals. All his teeth were removed at the hospital, but as he had no money to get new teeth, and as he was not referred to any dispensary for dental or other care, his condition was unknown to the agencies which might have assisted him. He felt his condition was almost as bad as when he first went to the hospital. The patient was referred by the worker for the Survey to the social service department of the dispensary to which he should have been referred, and he was immediately provided with the needed medical and dental care.

There is no one patient group probably for which the need for instruction has been so emphasized as the maternity patient. While the follow-up for such cases is excellently provided for by some of the hospitals, in others there is no plan for further care, as illustrated by the three following cases, all patients at the same hospital:

Case No. 12—The patient, a private patient, was a young Portuguese mother of 19 who had had her first baby. She was the type who would attend and would be much benefited by a well-baby conference such as is conducted at the Emporium. The mother and baby were in good condition, but the mother was entirely ignorant about feeding and baby care.

Case No. 13—This mother was in need of medical care and had just called her private physician who had delivered her at the hospital. The baby was well, although it was the mother's practice to nurse it whenever it cried. Its feet and legs were tightly wrapped, preventing any movement, and the surroundings were unhygienic, entirely lacking needed ventilation. This mother also is the type of patient who would attend a well-baby conference, but had not been recommended to the one in her neighborhood.

Case No. 14—This mother feeds her twins at irregular intervals and needs instruction in the general care of babies, also in the preparation of supplementary feeding. She was not referred to any well-baby conference and only consults her private physician in case of sickness.

The time to arrange for a patient's after-care is prior to discharge. It is natural to suppose that medical care includes inquiry regarding home conditions, instructions as to physical condition, and directions as to the course to be followed after leaving the hospital and, in those cases in which social service investigation reveals social or economic problems, reference to the social service department so that adjustments will be made which will insure the patient the particular institutional care needed. The following indicate that such medical supervision is not always provided:

Case No. 15—A little boy of three was discharged after six days in the hospital with a diagnosis not definitely determined but judged to be sub-acute tuberculous peritonitis. The mother was told to take him to the hospital's dispensary and was given detailed instructions about his care. The hospital's nurse had called and advised preventorium care, because, although the mother is intelligent and the child is receiving good care at home, as there are two other children under four, she had insufficient time to carry out the instructions. It was quite apparent that the mother's entire time was being taken up in care of the sick

child, to the detriment of the other children and to her own health. The question of preventorium treatment had not been taken up with the mother by either the doctor or intern, and although evidently recommended by the physician in charge of the case, its importance had not been brought home to the parents.

Case No. 16—Convalescent institutional care was indicated for a man of 38 who had been for a month in the hospital with chronic nephritis. He had had many previous attacks and had been ill and unable to work for over three months. He felt he had been much improved by his hospital stay, the puffiness had gone from his hands and feet, but he was still weak, thin and anemic. Previously he had done janitor work, and a physician at the hospital had told him he might be able to run an elevator. His physical condition indicated that he was not able to work, when visited shortly after discharge. His wife is lame and able to earn a little money by sewing at home. One of the relief agencies has given aid on different occasions, and at the time it was giving a quart of milk a week. It was the opinion of the visitor for the Survey that the wife was not able to provide the proper care and diet required by the patient's physical condition, and what he needed was institutional convalescent care, followed by occupational placement. He was referred to those conducting a study of the handicapped, in progress at the time, and employment suited to his condition was to be arranged for.

Case No. 17—A young woman of 21 with no family or home, who was in the hospital for over three weeks with heart disease, went to a rooming-house on discharge. She was working in a laundry, her legs and feet were swollen, and she felt she would soon have to return to the hospital again. This patient should have been in a convalescent institution where she would have the special medical supervision and be referred to an agency for assistance in obtaining work suited to her heart condition.

Occupational Therapy

Throughout the hospitals of San Francisco there are but two occupational aids, one each at the University of California, and the Lane and Stanford Hospitals. The well-known benefits to be obtained during the period of bed care of hospital patients through the stimulation and direction of occupations, provided by trained persons acting under medical advice, for therapeutic purposes can hardly be said to be appreciated by the medical or administrative staffs of the hospitals of the city. Occupation of patients of almost all types appears to aid in recovery, to make easier ward management, to abbreviate the length of stay of patients, and assist in many ways functional repair, particularly in surgical and orthopedic cases and among psychiatric patients.

It is understood that the salary of the occupational aid at Lane and Stanford Hospital is supposed to be a suitable burden for the Community Chest, and at University of California Hospital an appropriate item for the Women's Auxiliary to support.

The position of occupational therapeutist or aid in a general hospital should be as definite and integral a part of the hospital staff, as is the anesthetist, the dietitian or the dentist.

Instead of considering this a service only for the amusement of patients, and a matter of unconcern to the attending medical staff, this resource in the treatment of disease should be used intentionally by physicians and surgeons, by calling upon the occupational aid to plan for treatment as they do the serologist, the pharmacist and the dietitian.

While the simple occupations of bead work, jewelry, weaving and basketry serve to introduce the function of occupational therapy into the hospital household, they do not represent the full range and scope of manual trades, etc., which could be used with great advantage, especially among the 9 per cent of patients in San Francisco's Hospitals who have been bed patients for three months or more, many of them for several years.

A study of the uses of occupational therapy as developed in many general hospitals throughout the United States would be an interesting and probably a profitable undertaking for the proposed Hospital Council. The experience of the Massachusetts General and the Children's Hospitals in Boston, of Bellevue Hospital in New York, of Barnes Hospital in St. Louis, and of the Presbyterian Hospital in Chicago would be illuminating and stimulating to any of the hospital executives of San Francisco who have opportunity for observation of hospital work elsewhere.

Staff Conferences

Attention should be called to the meager development among the ten hospitals, of clinical staff meetings. A few of the medical staffs meet with regularity and review certain phases of professional care, but such review cannot be considered to be complete if the conference programs are limited to interesting or unusual cases, do not include the review of private patient's records, special patient groups and particular services, or do not include the presentation of cases which come to autopsy.

The organization of staff conferences, which are intended to serve the purpose of a professional forum before which every record of service may be brought for searching analysis as to method and result of treatment, is perhaps the most important function of a medical board.

Such conferences are growing steadily in value and suffer more from the lack of adequate preparation of the records upon which discussion must be based, than from indifference or lack of recognition of their worth. The points which should receive more attention from the several staffs are: (a) The use and results of consultant services where special problems of diagnosis and treatment are present; (b) The analysis of cause of death, particularly in obstetrical services and after operations of choice; (c) Infections following "clean" operations, post-operative pneumonia, etc.; (d) Unsatisfactory results of treatment requiring readmission, and (e) Complications which might have been avoided.

It does not appear that the weekly colloquia conducted separately by the different services of the two university staffs at the San Francisco Hospital meet all the requirements of staff review of professional performance.

Autopsies

One way of measuring the interest in and practice of scientific clinical medicine is by the percentage of deaths that come to autopsy. Where there is indifference as to the accuracy of diagnosis, or what Dr. Richard Cabot

so tersely described as the "sins of omission and commission," we find that little attention is paid to that final verification of medical skill or the humbling process of facing one's own error which can take place only at the post-mortem examination.

During 1922 according to the answers received from the hospitals by the Survey no autopsies were performed at St. Luke's, Mary's Help, or Mount Zion Hospitals among the 336 deaths which occurred in these institutions in the year. Apparently there were no autopsies performed at the French Hospital, the number of deaths, however, being omitted from the report from this hospital.

At the Franklin and St. Mary's Hospitals autopsies were performed in 1.9 per cent or four of the 208 deaths, and 8.1 per cent or eleven of the 135 deaths, respectively. At the Children's Hospital autopsies were performed in 39.5 per cent (sixty out of 152 deaths). At the three hospitals used for teaching purposes, with the attending staffs nominated by the medical schools, autopsies were performed as follows in 1922:

	Deaths	Autopsies	Per cent
San Francisco Hospital	599	137	22.8
Lane and Stanford	252	44	17.4
University of California	...	...	42.0

Making all suitable concessions for racial and religious prejudices and superstitions, it cannot be said that this is a good showing. There is little resourcefulness or determination used in securing consent for post-mortem examinations. This is distinctly a function of the hospital administration, although interest and persistence on the part of the attending and resident staff is a powerful aid to success. When the Montreal General Hospital, Peter Bent Brigham Hospital in Boston and Mount Sinai Hospital in New York can obtain consents for autopsies in over 85 per cent of the deaths there ought to be more than one hospital in San Francisco to claim as much as 42 per cent of autopsies.

(d) AREAS SERVED

Although the majority of the hospitals have some general idea of the sections from which they draw their patients, there is no definite knowledge on the subject as no studies have been made which would furnish these facts. In order to obtain information from which deductions could be drawn regarding the areas served by the several institutions, a study was made of the addresses of 6542 patients—representing the cases admitted to the ten hospitals during two months, November, 1922, and January, 1923.

The results of this study indicated that 84 per cent of the patients admitted during the period were residents of the city and 16 per cent were non-residents, the percentages varying for the individual hospitals, as follows:

Percentage of Residents Among Hospital Admissions, November, 1922, and January, 1923

	Percentage from San Francisco
PUBLIC INSTITUTIONS—	
San Francisco Hospital	99
University of California Hospital	64
(21 per cent no address or wrong address.)	
PRIVATELY CONTROLLED INSTITUTIONS—	
Children's Hospital	80
Franklin Hospital	80
French Hospital	91
Lane and Stanford University Hospital	65
Mary's Help Hospital	90
Mount Zion Hospital	89
St. Luke's Hospital	84
St. Mary's Hospital	78

Average 84 per cent.

In order to ascertain the specific areas served by each hospital, individual maps were prepared showing the geographical distribution of the patients admitted to each institution during the period specified. Based upon the results of this further study, the general areas served by the several hospitals are herewith briefly outlined:

Of the two public institutions, the San Francisco Hospital serves primarily the Potrero and Mission districts, the Western Addition, and those sections south of Market Street which border on the general neighborhood of the hospital; the University of California Hospital serving its own immediate locality and the section bounded by Stanyan, Seventeenth, Turk and Fillmore Streets, largely. The admissions to the first-named institution constituting the largest number of free patients cared for during the period studied, a further analysis was made of the sections served by this hospital, as shown in Map 2, page 69. As the city is not divided into the usual municipal health districts, the districts used are those commonly used in designating the various sections of the city.

Of the privately controlled hospitals, the Children's Hospital apparently serves all sections of the city, with the exception of the Potrero district. There does not appear to be any particular section which is served more than any other, the number of patients coming from the different parts of the city varying with the density of population.

The Franklin Hospital admitted patients from all sections of the city, there appearing to be no particular district served more than any other.

The patients admitted to the French Hospital came chiefly from the district bounded by Fillmore, Market and Larkin Streets, the neighborhood of Telegraph Hill and from its own neighborhood.

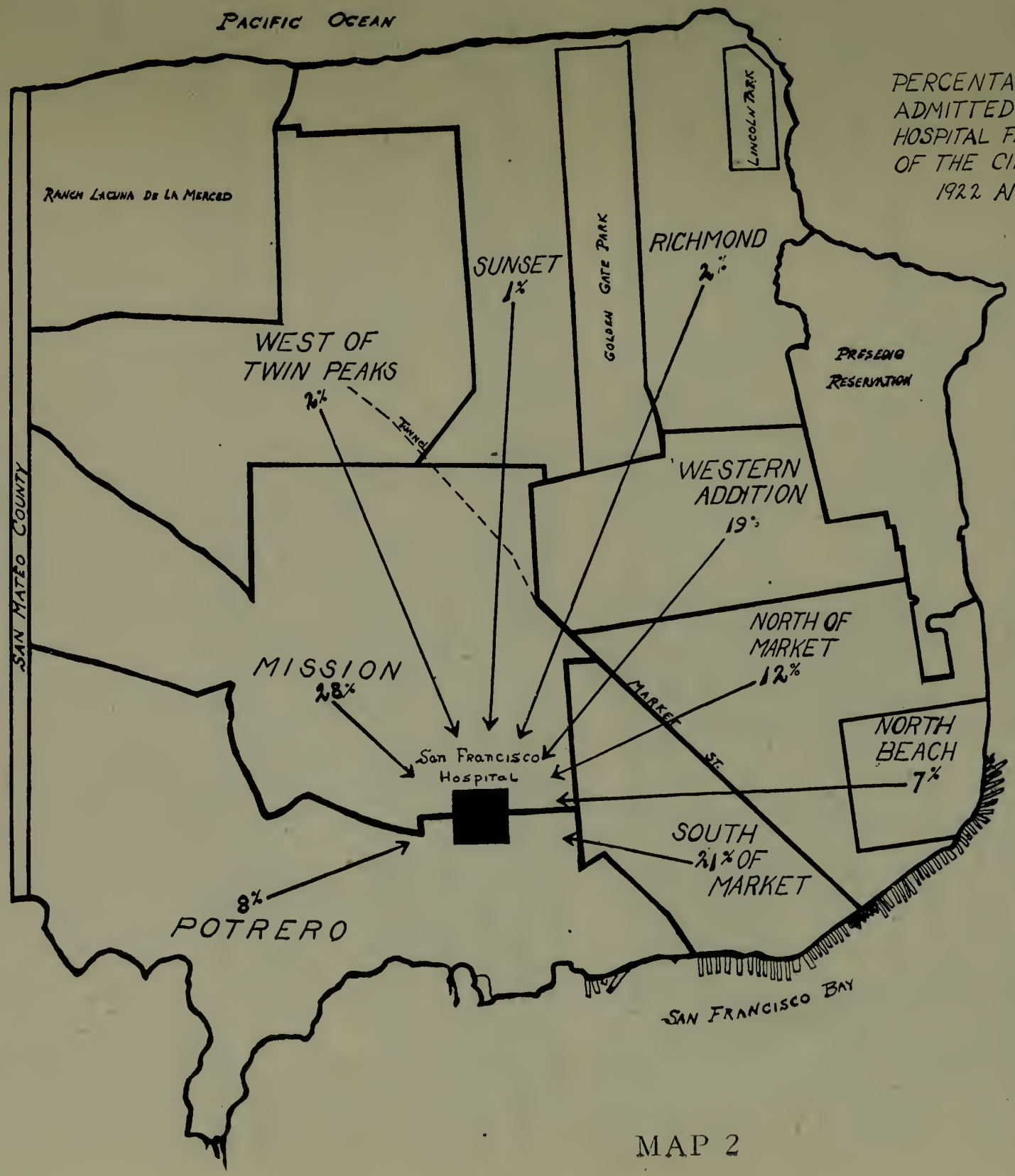
At Lane and Stanford University Hospital, though patients were admitted in large numbers from all sections of the city, the section served appears to be primarily that in which the institution is located.

Mary's Help Hospital serves chiefly its own immediate district—a fact which was also true of its dispensary service, based upon the addresses of new dispensary patients admitted during the same period.

Mount Zion Hospital, while admitting patients from all sections of the city, serves the general area north of Market Street out as far as Golden Gate Park, the great majority of the patients living in the section bounded by Market, Fillmore, Geary and Larkin Streets, and a large number coming from the hospital's own neighborhood. At this hospital, also, the new dispensary patients during the two months studied, came chiefly from the same general districts as the hospital cases.

At Saint Mary's Hospital, the greatest number of patients came from the hospital's own section of the city, although many of them were admitted from the general metropolitan area.

St. Luke's Hospital serves all parts of the city excepting the extreme western and eastern portions, the striking fact being the uniformity with which patients were received from all sections.



PERCENTAGE OF 1047 PATIENTS ADMITTED TO THE SAN FRANCISCO HOSPITAL FROM VARIOUS SECTIONS OF THE CITY, DURING NOVEMBER 1922 AND JANUARY 1923

MAP 2

These combined data reflect general and special areas served by the individual hospitals. It is to be expected that the two University hospitals admit patients from all sections and that most of the other institutions serve their own localities to varying degrees. The facts indicate that many of the hospitals draw from practically all sections of the city, and that Mary's Help, Mount Zion and St. Luke's Hospitals receive patients in greater proportion from their own neighborhoods.

HOSPITAL FINANCES

Of the two publicly maintained hospitals the San Francisco Hospital, supported by city taxes, has made no request for community support from the Chest. Matters of finance at this institution therefore were not considered by the Survey.

The University of California Hospital, supported by fees from patients, State taxes and income from endowments, furnished the Survey with a brief financial statement indicating the sources of income, and a total, but no items of expenditures.

Of the privately controlled institutions, the Children's, Mount Zion, St. Luke's, Mary's Help, St. Mary's and Lane and Stanford University Hospitals are supported by donations from the public, income from operation and interest on investments; St. Mary's and Mary's Help Hospitals receiving additional contributions represented by the services donated by Sisters.

The two remaining private institutions, the Franklin and French Hospitals, are the activities of mutual benefit insurance associations, and in addition to the income from operation, donations, etc., receive support from their respective actuarial memberships.

During the last fiscal years of the ten hospitals the total hospital income, including $713,000 expended for the maintenance of the San Francisco Hospital, amounted to $3,794,598.01. The several sources from which this sum was obtained were not clearly indicated in the financial information furnished, due largely to dissimilar accounting methods. The following table presents the facts in as much detail as the figures furnished permitted:

Sources of Hospital Income, 1922

	Public Taxes	Earnings from Operation	Donations, Interest on Endowments, etc.	Total Income
PUBLIC INSTITUTIONS—				
San Francisco	$713,000.00	.....	.....	$713,000.00
University of California	176,505.23	$339,301.09	$11,414.38	527,220.70
Totals	$889,505.23	$339,301.09	$11,414.38	$1,240,220.70
PRIVATELY CONTROLLED INSTITUTIONS—				
Children's	.....	265,073.90	.....	265,073.90
Franklin	.....	369,863.46	.....	369,863.46
French (Society and Hospital income not separated)	.....	.....	.....	233,395.46
Lane and Stanford University	.....	534,353.08	.....	534,353.08
Mary's Help	.....	152,402.41	14,700.00	167,102.41
Mount Zion	.....	249,590.41	100,438.53	350,028.94
St. Luke's	.....	292,759.57	34,681.27	327,440.84
St. Mary's	.....	283,719.22	23,400.00	307,119.22
Totals	.....	$2,147,762.05	$173,219.80	$2,554,377.31
Grand Totals	$889,505.23 *(25%)	$2,487,063.14 *(70%)	$184,634.18 *(5%)	$3,794,598.01 *(100%)

The foregoing is assumed to be indicative of the general situation regarding the sources of hospital income. It is probable that the considerable donations and endowment fund income of the Children's Hospital, which do not appear on the foregoing table, would not materially increase the percentage of total income thus derived, as they would be largely offset by the income from operation of the French Hospital—an item which also was not furnished the Survey.

Special mention should be made of the matter of the free services donated by the Sisterhoods conducting St. Mary's and Mary's Help Hospitals. As Sisters' services represent a financial saving to a hospital, the actual money equivalent should be estimated and listed as a donation from the Sister personnel. The amounts, therefore, listed as income from donations at St. Mary's and Mary's Help Hospitals represent the money equivalent of donated Sisters' services, and were computed by the Survey on the basis of current salaries for the positions held by Sisters in these two hospitals. The importance of the contribution of the Sisterhoods maintaining the two hospitals does not receive due recognition unless this is done. In securing cost items for purposes of comparing costs with those of other institutions, such estimates should be included as salary items, and, in recognition of the services donated free by the Sister personnel, they should be included in public statements of funds, contributions, materials, etc., donated to these hospitals.

*French Hospital income eliminated in finding percentages.

The finances of the French and Franklin Hospitals present special problems as these two institutions are essentially the undertakings of mutual benefit organizations. As the French Hospital did not furnish the Survey with the financial information supplied by other institutions, the facts reviewed were those contained in the organization's last-published report. These indicate that the hospital and Benevolent Society are conducted as a unit and that the undertaking for the fiscal year, ended in March, 1923, showed a profit of some $14,000. The facts furnished by Franklin Hospital indicate that the institution is a subsidiary of the German General Benevolent Society, to which rental is paid for the use of the hospital plant. For 1922 the hospital showed a net profit from operation of $545, which sum was applied to the reduction of the $34,000 deficit arising through the mutual insurance activities of the Society.

The total expenditures of the ten institutions during 1922, amounting to $3,752,412.70, is shown for the individual hospitals as follows:

Hospital Expenditures, 1922

PUBLIC INSTITUTIONS—	
San Francisco Hospital	$ 713,000.00
University of California Hospital	527,220.70
Total	$1,240,220.70
PRIVATELY CONTROLLED INSTITUTIONS—	
Children's Hospital	280,433.18
Franklin Hospital	369,317.47
French Hospital (Society expenses included)	219,303.19
Lane and Stanford University Hospital	585,419.38
Mary's Help Hospital	152,109.02
Mount Zion Hospital	335,607.40
St. Luke's Hospital	317,490.74
St. Mary's Hospital	252,511.62
Total	$2,512,192.00
Grand Total	$3,752,412.70

Due to the incompleteness and the differences of classification of expense items, it was not possible to analyze the relative amounts expended for the various items of hospital maintenance. These are important as indications both of service given and administrative policy, in that they show the amounts expended for the various phases of hospital work.

The following table showing the relative percentage of the total expenses for each of the eight principal items of hospital operation, in a group of seven hospitals recently studied in New York City, is herewith presented as an indication of the precentage analyses which are possible when the needed facts are available:

Percentage Distribution of Expenditures by Eight Principal Items (Seven Hospitals—New York City)

Hospital	Salaries	Medical and Surgical Supplies	Clothing, Bedding, Misc.	Provisions	Post Stat'y, etc.	Insurance Interest on Mortgages and Loans	Fuel, Light and Water	Repairs on Buildings, Furniture, etc.
	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent	Per cent
No. 1....	16.9	6.8	6.4	46.0	1.4	6.8	7.8	7.9
No. 2....	31.3	11.5	5.4	33.2	1.5	.1	7.7	9.3
No. 3....	43.5	7.5	1.6	22.0	1.2	.1	11.8	12.3
No. 4....	25.4	7.8	12.0	26.3	1.4	3.7	11.2	12.2
No. 5....	30.6	14.4	4.9	25.4	1.4	5.4	13.3	4.6
No. 6....	26.4	9.2	6.3	30.8	1.6	1.8	10.8	13.1
No. 7....	17.3	4.4	9.9	48.8	1.1	.3	12.9	5.3

It is evident that the effective use of such large and active investments requires careful financial planning, including budgetary methods and modern cost accounting—in other words those financial policies and practices that are endorsed as sound and reasonable for the conduct of public trusts generally.

The chief defect of the financial operation is the almost general absence of these evidences of financial planning. For example, although some of the hospitals, notably the University of California and Mount Zion Hospitals, make some use of budgetary methods, the information obtained indicates that, at the first named, departmental and general per capita costs do not enter largely into budget consideration and at the latter, that but three of the departments are operated on budgets.

In hospital operation an adequate financial plan includes the determination of an annual budget for each department based on its past performance, use and needs, and the co-ordination of these departmental budgets in a combined budget for the institution as a whole. It includes also consideration of the expenditure of funds for the purchase of new equipment, education of personnel, new activities, etc., as well as those for the routine operation of the institution.

In order to make and carry out a comprehensive and effective financial plan it is necessary for each managing board to consider departmental reports of work done, monthly statements of receipts and expenditures, current departmental and per capita operating costs, and a comparative budget and expense statement. Although the hospital boards receive monthly financial reports, many of them showing departmental receipts and expenditures, these are not associated with analyses or records of work done and even in those institutions where they have been established, cost units do not appear to be reviewed.

Accounting Systems

The work of the Survey included the collection of only general facts regarding accounting methods and financial policies.

It is recognized that there necessarily enter into the operation of the University of California and Lane and Stanford University Hospitals

complex questions of cost distribution, in order to determine hospital operating costs as differentiated from medical school operating costs.

These costs are somewhat segregated at Lane and Stanford University and are now undergoing analysis and revision at the University of California, although general facts gathered at the latter suggest that as yet there has been no separation of the cost of private room patients and ward patients, and that the accounting system does not readily furnish unit per capita costs.

Based on the facts ascertained, it is evident that the accounting systems of the majority of the hospitals are in general of the type considered satisfactory some years ago, but unsuited to many phases of present day hospital operation.

All of the defects encountered are not common to each institution but there were sufficient evidences to indicate that among the deficiencies are, the lack of periodic audits, modern inventory methods, and operation on a cash rather than an accrual system. Some of the hospitals have their books audited regularly by certified public accountants. Others have excellent stores and inventory methods and in still others an accrual system is in effect.

The varying methods of estimating free service in the different institutions further indicate the need for the introduction of modern cost methods. This is illustrated in the fact that more than one hospital bases the cash value of its free service on prices charged and not on cost. Thus, in one hospital, if a free patient, because of his condition, is placed in a separate room, the free work of the institution is credited with the scheduled price of the room, and not the cost of hospital maintenance; conversely, when ward care for which $2.50 a day is charged is given free, the hospitals free work is credited with this amount instead of the actual per capita cost, which is over $4. In another of the hospitals, laboratory examinations furnished free are listed in the hospital's free work at scheduled prices instead of at cost. It must be clear that if a room costing $4 a day to maintain is listed at $6 work of free service, or if laboratory examinations costing $1 are listed at $3 worth of free work, entirely fallacious totals are built up, bearing no relation to the actual cost of the free service furnished. We cannot give away something we do not possess and we cannot give away $6 worth of care that costs but $4, nor $3 worth of laboratory service that costs but $1. The consensus of lay opinion would certainly be to the effect that public contributions for hospital care are made in order that free treatment will be available to those unable to pay the cost of hospital service, and that the only charge to the free account for that service which is rendered free, should be the actual cost to the hospital of such service.

Probably the most general defect is that accounts are not kept with a view to careful self-analysis as to cost of work done, essentials of which are the cost of hospital operation as a whole, the cost of the operation of the different departments, and the unit costs of the various types of service. This information is essential in determining expendi-

tures, allocating waste, setting rates, measuring efficiency, and for purposes of comparison with other institutions conducting similar work.

Of the unit costs, the one most important and generally most used, is the per capita per diem cost—the amount representing the average daily cost of caring for one patient. Deductions based on this cost, to be of value, should be correlated with facts regarding hospital operation, whether, for instance, a low per capita cost is due to poor equipment, many chronic patients, undue crowding, etc., or conversely, whether a high per capita cost is due to a low degree of use of the hospital's beds, to the maintenance of costly diagnostic and treatment facilities, to uneconomical administration, etc.

The per capita per diem costs herewith presented were furnished by the institutions, with the exception of St. Mary's and the French Hospitals, in which cases the costs were estimated by the Survey on the basis of the total number of days' care compared with the total cost of operation, this cost at the latter institution including expenditures for both the Society and the hospital.

In presenting these cost data, it should be understood that in many instances they represent a blanket cost for both private and ward patients, for which the facilities, services, and maintenance vary considerably. For example, when a hospital states that the per capita cost of its bed care is $5 or $6 a day for all patients, it does not mean that $5 or $6 a day is expended to maintain all classes of patients, whether in the wards or in private rooms. What it does mean is that patients paying high rates and receiving increased service, superior surroundings and more expensive foods, raise the average cost for the care of ward and semi-private patients for whom comparable provisions are not furnished, and does not represent the true cost of care given to the majority of free and part-pay patients.

The individual per capita per diem costs of the nine hospitals during 1922, were as follows:

Hospitals	Per Capita Per Diem Costs
Children's Hospital	$4.77
Franklin Hospital	4.86
French Hospital	4.46
Lane and Stanford University Hospital	4.85
Mary's Help Hospital	4.08
Mount Zion Hospital	7.04
St. Luke's Hospital	6.74
St. Mary's Hospital	4.43
University of California Hospital	4.16

These data, which show a wide range in the cost of hospital care, are pictured in Chart D, page 77.

Hospital Rates

In view of the fact that there is considerable sentiment in San Francisco to the effect that the prices charged for bed care, laboratory services, and for special treatments, are in general high and provide small opportunity for hospitalization, diagnosis and treatment at moderate rates, information was collected relative to the current rates for children, adults and maternity patients and for laboratory examinations.

It is believed that more complete facts might modify the figures derived from the information furnished, shown in the following table, but they represent a summary of the information as obtained from the hospitals on direct inquiry:

Beds for Children (Medical and Surgical Conditions)

	Number of Beds	Per Cent	
Under $2 a day	...	..	
$2 to $3 a day	114	58	58
$3 to $4 a day	23	12	
$4 to $5 a day	55	28	
Over $5 a day	2	2	42

Beds for Adults (Medical and Surgical Conditions)

	Number of Beds	Per Cent	
Under $2 a day	...	..	
$2 to $3 a day	15	1	
$3 to $4 a day	392	28	29
$4 to $5 a day	420	30	
$5 to $10 a day	556	40	
Over $10	10	1	71

Beds for Maternity Patients

Under $3 a day	...	...	
$3 to $4 a day	33	23	
$4 to $5 a day	50	34	57
$5 to $10	61	43	43

ESTIMATED COST OF HOSPITAL CARE IN SAN FRANCISCO – 1922

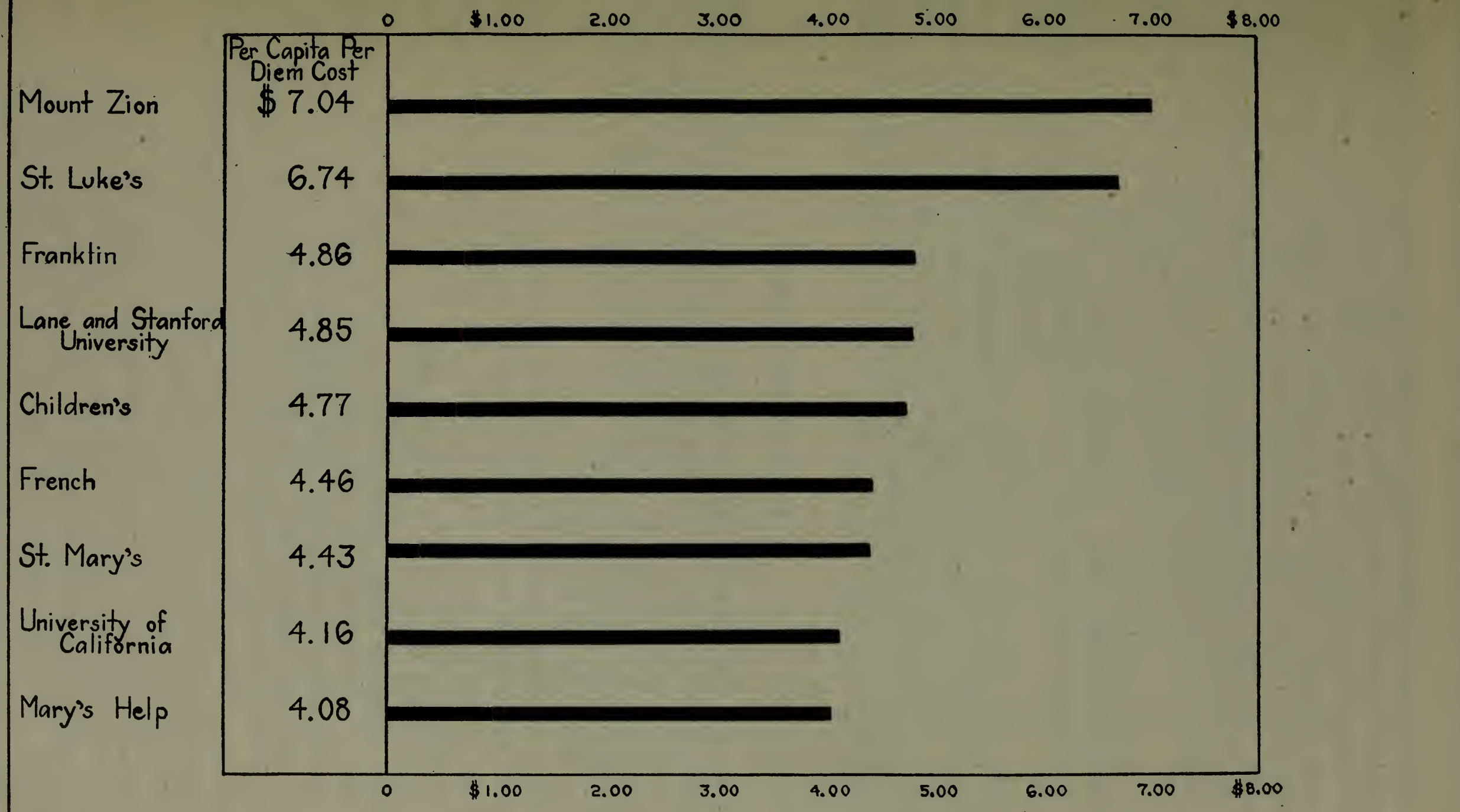


CHART D

While these facilities show a high percentage of accommodations at more than moderate rates—only about one-fourth of the facilities being offered at prices ranging from $21 to $28 a week—actually in practice these are at times waived to accommodate patients who cannot afford to pay the full cost of the scheduled rates. Many of the hospitals allow discounts on bed care, laboratory examinations, special treatments, etc., some of these discounts being generous. Several patients visited during the course of the convalescent study of the Survey had not paid in full for their care, either for their ward or room beds, or for special and extensive diagnostic and treatment services required by their condition.

Based upon the brief material available for study, it is evident that some adjustment in the rates is needed in order to serve equally all the economic groups of the population. The specific provisions which should be made can only be determined by a co-ordinated study on the part of the hospitals. The Survey has insufficient knowledge upon which to base conclusions of value except that, in view of the preponderance of facilities costing over $4 and $5 a day and the difficulty experienced by physicians and interested lay workers in hospitalizing part-pay patients, a further detailed study of the subject by the hospitals themselves appears urgent.

Laboratory Charges

One of the matters receiving attention from hospital authorities is the regulation of fees for laboratory examinations. The practice of charging a separate fee for each examination is being discontinued and a flat fee to cover all pathological laboratory work is being substituted. This substitution has been introduced at the University of California, Mount Zion, and St. Mary's Hospitals.

More recently leading hospital administrators are regarding the cost of laboratory work as a general hospital expense and discontinuing the charging of special and separate fees. In order that the cost of operating the laboratory department shall be met, the actual cost of maintaining the department is divided by the number of days of care furnished, the resulting small amount being added to the existing room or ward rate.

Thus, a hospital may find that the total cost of its pathological laboratory, when spread over the total days of care, increases the cost by 25 cents per patient day. Rooms that were $4 a day are thus raised to $4.25 a day and no separate item for laboratory examinations appears on patients' bills. (Mount Sinai Hospital, Cleveland, an institution operating extensive laboratory departments, estimates the cost of its pathological laboratory at 16 cents per patient day.)

Similar methods for apportioning the cost of X-ray examinations have been adopted to only a small extent, although recognized as correct in principle. The amount which will be required to meet the cost of a hospital's X-ray department can be fairly well determined by predicating cost and volume of work upon the last six months' or years' experience of the department's activities and cost of operation.

Hospital operation at present shows similar instances of cost distribution. Thus, no separate charge is made for the services of a dietitian, although the treatment of individual patients frequently requires considerable time and attention from dietary departments. Again, hospitals make no charge for the services furnished by social service departments, although these also are available and used for other than free patients. There is no apparent reason why a patient should pay for an examination of his blood, which is one phase of hospital service, any more than for the services of a dietitian, or of a social service worker.

It must be obvious that the determination of the amount which should be added to the daily rate to cover laboratory costs when distributed as a general cost, can only be undertaken when the individual operating costs of laboratory departments are known.

Even a brief review of the laboratory rates now charged in the nine hospitals indicates that some are out of all proportion to the cost and are comparable to those charged in commercial laboratories which naturally expect to make a good profit. Thus a rate of $5 for a Wassermann test—an examination which costs from 20 cents to 30 cents in a well-managed laboratory—is excessive. In X-ray departments likewise, in many instances, the prices charged are not based on cost, even for dispensary patients. For example, the price charged for an X-ray examination of a hand, arm or finger—$5 to $10 in some of the hospitals—shows a considerable margin of profit. This is also true regarding X-ray examinations of teeth, the price varying from $5 for complete X-ray with $1 for one tooth, to $15 for complete X-ray, with $2.50 for one tooth.

The adoption of a policy of "no extras" on patients' bills for these scientific examinations is desirable and should be agreed to. San Francisco hospitals have here an opportunity to crystallize hospital opinion by the adoption of a program which will provide examinations and treatments upon a basis of diagnostic and therapeutic necessity, rather than on an arbitrarily determined economic basis.

SUMMARY

It is clear that these ten hospitals, founded upon definite needs in the community life, constitute a dominant factor in the work of the city for the care of the sick. Their boards and staffs are responsible for the medical standards surrounding the care of at least three-quarters of the city's sick who enter hospitals and over 90 per cent of those who receive dispensary service.

This intimate contact with thousands of the population offers enviable opportunities for the care of the sick, the prevention of sickness and the promotion of health, matters which the progress of medicine renders yearly of increasing importance. Institutions which, like these ten hospitals, are spending millions of dollars annually for such purposes, need not only managing boards which concern themselves with the details of administering particular institutions, but also a central body free to think out those broader policies which will increase the efficiency of health and

medical work throughout the community and enable every dollar to bring the greatest return.

In the opinion of the Survey, the chief lack in the San Francisco hospital field is the absence of contact among the individual units of this large community undertaking. The institutions, with common aims of public service, have no unifying organization or program for the effective accomplishment of the work in which they are each individually engaged, nor is there a central authoritative group equipped to study particular problems and plan for their solution.

There is needed a well-organized co-operative group which could formulate general standards, suggest policies and determine programs for dealing with the particular problems of the hospitals of San Francisco.

The need for some plan for co-operation is appreciated. The general sentiment among hospital boards and executives favors a commonsense working basis for the co-ordination of hospital policy and of certain aspects of hospital administration, the elimination of known duplications and wastes and for the mutual benefit which would result from unified effort and joint planning.

Hospital Council

The success of joint councils suggests that the hospitals would derive benefits and stimulus from the establishment of a Hospital Council—in fact every indication for progress points toward the advisability and practicability of such a co-operative effort.

A Hospital Council, properly organized, would leave undisturbed the executive powers of the individual hospitals, and provide a central advisory and co-operative service; the Council to serve primarily as a volunteer organization for the development of improved hospital service and economy of hospital operation, to enjoy delegated powers only, and to influence hospital affairs through the confidence which it inspires and the authority thus established.

Such a Council should include representatives of the boards and the executives of all the hospitals of the city and men and women from professional and business groups, as follows:

(a) One member from the board of each hospital.

(b) The hospital executives.

(c) Additional members at large to include preferably a representative of the County Medical Society, a lawyer, a financier, an accountant, a representative of the Council of Social Agencies and several women of broad interests, one of them, preferably, an educator.

Such an organization would enable the experience of each institution to be of benefit to all and would break down the tendency to isolation which is characteristic of institutions without a central co-ordinating organization.

To be effective, the Council should organize with officers and committees, and provide for at least monthly meetings. The more important standing committees should be appointed, and provision made for the appointment as needed of special advisory or study committees with extra-Council membership.

In order to accomplish results and obtain the fullest advantage accruing from co-ordinated effort and pooled experience, it is essential that the Council employ an ably equipped, whole-time executive secretary.

The initial Council activity which could be undertaken with advantage, and which would render immediate services to the hospitals is a central purchasing department.

The experience of the Cleveland Hospital Council is indicative of the large benefits accompanying the establishment of such a co-operative service. During 1922 over $700,000 was expended by its purchasing bureau, with great saving to the hospitals and other institutions, and much improvement of service in the matter of deliveries, etc.

Not the least important use of a centralized purchasing system is the expert advisory service made available for studying market conditions, contracts, etc.

It would probably be necessary to establish an initial revolving fund so that cash discounts might be taken. The saving thus effected would, for the eight private hospitals alone, be considerable. During 1922, less than $1000 was thus earned, although experience demonstrates that cash discounts will equal one-half of one per cent of the total expenditures of hospital operations—an amount in the eight hospitals of approximately $12,500.

In addition the following problems, regarding which there already exists considerable knowledge and opinion, warrant early group attention:

(a) There is need for the establishment of uniform standards for reporting those medical administrative and financial statistics recognized as essential as a basis for guiding medical, financial and administrative policies. The monthly report form adopted by the Cleveland Hospital Council for reporting similar facts to the Cleveland Welfare Federation appended to this report (see page 145, Section V) gives the items which should be collected.

(b) A study of hospital rates, with special reference to the needs of families of moderate means, correlated with facts as to part-pay patients admitted and those applying and not admitted, all assembled uniformly by all the hospitals would furnish a basis upon which to determine the provision which must be made.

In this connection, consideration should be given to the question of the establishment of part pay facilities at the San Francisco Hospital, as furnished by municipal hospitals in other cities—notably Bellevue Hospital, New York City, and the Buffalo General Hospital, Buffalo, N. Y.

(c) There is need for more complete information regarding the

problems of the chronically sick. The collection of facts on this subject over a considerable period would provide a basis for determining the extent of the need and for suggesting a program to meet it.

(d) The economy of a central collection service to which unpaid hospital accounts could be turned over for collection is a subject requiring particular study. A similar service instituted two years ago by the Cleveland Hospital Council[7] has four main objects: "1. Collect 'collectable' accounts at the lowest cost. 2. Prevent 'Current' accounts from becoming 'dead' accounts and reduce to a minimum amounts charged off as 'accounts uncollectable.' 3. Fix the status of every account within six months as 'collectable,' 'uncollectable' or 'collected.' 4. Reduce amounts to be charged off to a minimum every six months."

(e) The question of obtaining recruits for the schools of nursing is a problem in almost every one of the hospitals. This important subject deserves the attention of a special committee or a permanent subcommittee, representative of all the training schools and various professional nursing groups. It would naturally concern itself with such matters as the formulation of a program to reach high schools, normal schools, and women's colleges, direct attention to the excellencies and special opportunities of the various schools and would be effective in focusing attention on questions of group instruction during the preliminary period, need for opportunity in visiting nursing, the non-educational and non-nursing work now performed by student nurses in the hospitals, and the need for practical experience now lacking, such as medical social service, communicable disease nursing, including tuberculosis and venereal diseases, etc.

(f) The question of hospital personnel, the ratio of personnel to patients, the establishment of standards for salaries, wages, hours of work, and provisions for initial and periodic health examinations of hospital workers in order that the sick will be surrounded only by the well, are matters which would benefit through persistent study.

(g) Co-operative relationships should be established with the leaders in the Chinese health movement in San Francisco, with particular reference to the plans now developing for a hospital and dispensary for the Chinese, under Chinese direction and control.

(h) Benefit would result from collective attention to matters of hospital administration. There are at present unsolved problems which need careful consideration. The publication of annual reports, membership in national associations, attendance at national conferences and meetings of hospital executives and department heads, departmental organization, reports of work done, personnel, salvage, sale of materials, the use of labor-saving devices, etc., stores procedures, repair of surgical equipment and appliances, and similar subjects, are all worthy of study in the interest of hospital economy and good public service.

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7 The Cleveland Hospital and Health Survey—Two Years After. Cleveland Hospital Council, 1921-1922.

Chapter 2

DISPENSARIES

The organized dispensary service of the city is furnished by nine institutions, six of them hospital out-patient departments and three of them independent organizations:

Hospital Dispensaries

University of California Hospital.
Children's Hospital.
Lane and Stanford University Hospital
Mary's Help Hospital.
Mount Zion Hospital.
St. Luke's Hospital.

Independent Dispensaries

Homeopathic Clinic.
San Francisco Polyclinic.
San Francisco Neighborhood Association, conducting the dispensary commonly called Telegraph Hill.

In addition to the foregoing, occasional clinic sessions for general and special patient groups are conducted by St. Mary's and the San Francisco Hospitals, and consultation or treatment hours are held at regular times by the Franklin and French Hospitals, Although these four institutions have at their command the supplementary services required for adequate medical care, they cannot properly be classed as affording dispensary service in the present day meaning of the term. The Osteopathic Clinic, lacking adequate provision for diagnosis and treatment, is not here included.

The dispensary facilities at these nine institutions are indicated by the number of clinic sessions held weekly and the number of hours of service offered. The number of clinic sessions held weekly during the morning, afternoon and evening hours, are as follows:

Dispensary Facilities of San Francisco

	Number of Clinic Sessions Weekly			
	Total Sessions	Morning Sessions	Afternoon Sessions	Evening Sessions
Hospital Dispensaries				
PUBLIC INSTITUTIONS—				
University of California	129	87	36	6
PRIVATELY CONTROLLED INSTITUTIONS—				
Children's	48	42	6	..
Lane and Stanford University	67	54	12	1
Mary's Help	57	57	..	..
Mount Zion	73	67	6	..
St. Luke's	50	41	9	..
Totals	295	261	33	1
Independent Dispensaries				
Homeopathic	28	27	1	..
Polyclinic	51	51	..	..
Telegraph Hill	21	2	19	..
Totals	100	80	20	..
Grand Totals	524	428	89	7

The foregoing table does not include the following: (a) the morning, afternoon and evening office hours held by salaried physicians of the Franklin and French Hospitals, chiefly for members of the mutual benefit associations conducting the two hospitals; (b) the Orthopedic Clinic conducted by St. Mary's Hospital three mornings weekly; and (c) the five morning and one evening Chest Clinics and the one afternoon Prenatal Clinic held at the San Francisco Hospital weekly.

The scheduled number of hours weekly, represented by the 524 clinic sessions, are shown in the following table:

Dispensary Facilities of San Francisco

	Number of Clinic Hours Weekly							
	Total Hours		Morning Hours		Afternoon Hours		Evening Hours	
	No.	Pct.	No.	Pct.	No.	Pct.	No.	Pct.
Hospital Dispensaries								
PUBLIC INSTITUTIONS—								
University of California	336	27	258	25	72	38	6	75
PRIVATELY CONTROLLED INSTITUTIONS—								
Children's	78	6	60	6	18	10	..	..
Lane and Stanford University	196	16	172	17	22	12	2	25
Mary's Help	171	14	171	17	..	..	..	..
Mount Zion	208	17	197	19	11	6	..	..
St. Luke's	81	7	69	6	12	6	..	..
Total	734	60	669	65	63	34	2	25
Independent Dispensaries								
Homeopathic	45	3	44	4.5	1	.5	..	..
Polyclinic	56	5	56	5	..	..	..	..
Telegraph Hill	56	5	4	.5	52	27.5	..	..
Total	157	13	104	10	53	28	..	..
Grand Total	1227	100	1031	100	188	100	8	100

As 91 per cent of the clinic sessions shown in the preceding table are scheduled for the working hours of the day, they afford small opportunity for dispensary care in the free time of wage earning groups, one of the groups for which dispensary service is chiefly maintained.

The concentration of the clinic sessions in the morning hours, pictured in Chart E, page 87, represents a considerable unused investment in dispensary space and equipment. It will be seen that, although some of the institutions use their plants for a few afternoon clinics, practically no use is made of them during the evening.

The number of physician-hours of service actually provided per 100,000 of population—the correct basis for estimating hours of dispensary service—is not possible until physicians' registries are used uniformly in each institution. With such facts available, analyses can be made by the individual dispensaries of the amount of physicians' time devoted to original and return patients.

MEDICAL SERVICES PROVIDED

From the standpoint of medical care, the character and type of medical services offered are reflected in the facilities provided for general and special patient groups, and the number of hours available for each group. These facts are shown in the accompanying table:

HOURS OF SERVICES OFFERED BY SAN FRANCISCO DISPENSARIES EACH WEEK

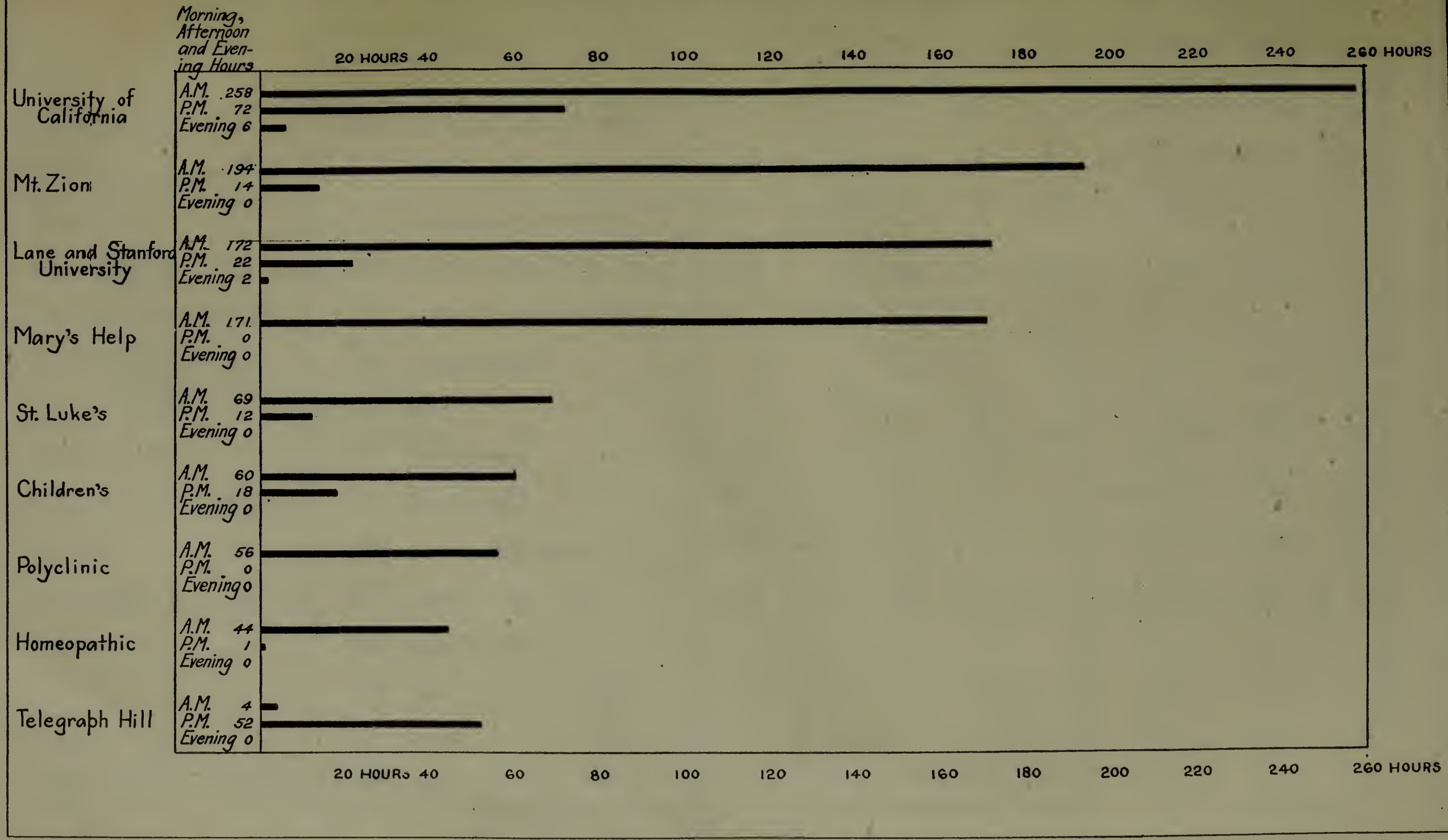

CHART E

Weekly Hours of Dispensary Services to Patient Groups

	Hospital Dispensaries							Independent Dispensaries				Total Hours Weekly
	Public	Privately Controlled										
	Univ. of California	Children's	Lane and Stanford	Mary's Help	Mount Zion	St. Luke's	Total Hours	Homeopathic	Polyclinic	Telegraph Hill	Total Hours	
General Medicine												
A. M.	33	3	18	24	12	10	106	18	6	..	24	130
P. M.	12	..	..	..	..	2	14	..	..	..	..	14
General Surgery												
A. M.	18	6	18	18	18	12	90	3	8	..	11	101
P. M.	12	..	..	..	..	2	14	..	..	28	28	42
Pediatrics												
A. M.	18	12	22	19	20	11	101	4	6	2	12	113
P. M.	12	..	..	..	3	3	22	..	..	14	14	36
Gynecology												
A. M.	18	..	18	18	18	6	78	10	6	..	16	94
P. M.	..	..	..	..	..	..	..	..	..	2	2	2
Eye, Ear, Nose and Throat												
A. M.	36	6	..	36	36	10	124	..	9	..	9	133
P. M.	12	..	13	..	..	2	27	1	..	6	7	34
Genito-Urinary and Urological												
A. M.	18	1	18	9	18	3	67	3	8	..	11	78
Eve.	3	..	..	..	..	..	3	..	..	..	..	3
Venereal Disease												
A. M.	18	..	..	..	..	..	18	..	..	..	..	18
Eve.	3	..	2	..	..	..	5	..	..	..	..	5
Orthopedic												
A. M.	18	6	18	9	6	2	59	..	2	..	2	61
Neurological and Mental												
A. M.	18	1	18	9	6	..	52	..	2	..	2	54
P. M.	..	..	3	..	..	1	4	..	..	..	..	4
Dental												
A. M.	..	18	15	27	18	10	88	2	6	..	8	96
P. M.	..	18	..	..	8	..	26	..	..	..	..	26
Prenatal												
A. M.	..	4	3	3	6	3	19	2	1	..	3	22
P. M.	12	..	2	..	..	1	15	..	..	2	2	17
Dermatology												
A. M.	18	3	18	..	18	2	59	2	2	..	4	63
P. M.	..	..	..	..	..	1	1	..	..	..	..	1
Heart												
A. M.	18	..	..	..	..	..	18	..	..	..	..	18
Physiotherapy												
A. M.	18	..	..	..	12	..	30	..	..	..	..	30
P. M.	12	..	..	..	..	..	12	..	..	..	..	12
Tuberculosis												
A. M.	9	..	6	..	..	..	15	..	..	2	2	17
P. M.	..	..	..	..	3	..	3	..	..	..	..	3
Totals												
A. M.	258	60	172	171	194	69	924	44	56	4	104	1028
P. M.	72	18	22	..	14	12	138	1	..	52	53	191
Eve.	6	..	2	..	2	..	8	..	..	..	..	8

HOURS OF DISPENSARY SERVICE OFFERED TO PATIENT GROUPS EACH WEEK IN SAN FRANCISCO

	Morning Hours	Afternoon Hours	Evening Hours
	No. Hrs.	No. Hrs.	No. Hrs.
General Medicine	130	14	0
General Surgery	101	32	0
Pedriatrics	113	36	0
Gynecology	94	2	0
Eye, Ear, Nose and Throat	133	34	0
Genito-Urinary and Urology	78	0	3
Venereal Disease	18	0	5
Orthopedic	61	0	0
Neurological and Mental	54	4	0
Dental	96	26	0
Pre-Natal	22	17	0
Dermatology	63	1	0
Heart	18	0	0
Physiotherapy	30	12	0
Tuberculosis (Chest)	17	0	0

0 50 HOURS 100 150

CHART F

The foregoing facts, also pictured in Chart F, page 89, not only emphasize the preponderance of morning clinic sessions and the meager provisions for afternoon and evening dispensary care, but also show that the provisions other than those available in the morning, are only for special patient groups.

The range of general and special patient groups for which provision is made, indicates that dispensary service in San Francisco is well developed for the general services and, to a considerable degree for the more special services, but that there is need for further development of facilities for the supervision of pregnant women, patients with heart disease, and those with venereal diseases.

There should be some facilities for evening clinics for the benefit of persons with venereal diseases, cardiac patients, and for certain other patient groups who work. This would not necessitate having elaborate equipment, but would serve as a means of helping people improve in health by having a place where they could obtain medical care and treatment at cost, after working hours.

Certain of the special clinics reflect commendable increasing hospital participation in sickness prevention and community health affairs. Among them might be mentioned the Posture Class at Lane and Stanford University, the Well Baby Clinics at Telegraph Hill, Lane and Stanford University and Mount Zion, the Chest Clinics maintained by the Board of Health at the University of California, Telegraph Hill, Lane and Stanford University and Mount Zion, those for Orthodontia at Mary's Help, the clinics for school children held at Mount Zion, etc. Another development thoroughly in accord with modern health service, is the Health Examination Clinic for Adults at the University of California, now in process of formation.

The lack of reciprocal medical records of patients referred from some of the hospitals to their out-patient departments or to independent dispensaries interferes with the continuity of medical care and hampers social follow-up of patients. The results of this lack are illustrated by the following case:

Case No. 18—A six and a half months' old baby in the hospital for two weeks with tonsillitis, otitis media, cystitis and cervical adenitis, was discharged as cured, the mother being told to take the child to an independent dispensary in her neighborhood so that a urine examination could be made weekly. The dispensary had received a telephone message from the hospital stating the patient had been discharged, but no medical history, diagnosis, treatment or notes as to further care were forwarded from the hospital. When the mother took the baby to the dispensary, she was referred to the well-baby clinic. As the physician in this clinic took up the matter of diet and weight and asked no questions which would have brought out the hospital history, nothing was known about the conditions for which the patient had been treated, or the further care ordered by the hospital doctor. The dispensary is not equipped to make urine examinations.

Similarly, patients under dispensary supervision for long periods may be sent to hospitals for bed care without any advantage accruing to either the patients or the hospital doctors from the accumulated clinic expe-

rience, due to the fact that the medical records of clinic care do not always accompany patients to hospitals.

The foregoing defects are noticeable omissions in the medical care provided for patients admitted to the San Francisco Hospital who also attend the out-patient departments of the two university hospitals. These two hospitals have excellent reciprocal records for their own in and out-patient departments, but similar standards of medical supervision have not been instituted for their patients who are treated at the San Francisco Hospital.

ORGANIZATION AND EXECUTIVE CONTROL

But two of the hospital dispensaries, the out-patient departments of Mary's Help and the University of California Hospital, approach, in organization and executive direction, the standards advocated for modern dispensary operation. At these institutions, most of the functions of management of the dispensaries are centered in one individual whose chief responsibility is the direction of the department.

At Lane and Stanford University the out-patient department is a department of the Medical School, and there is no one person charged with its management and giving it his main attention.

At Mount Zion and Children's Hospitals, although the dispensaries are hospital departments, direction is not centered in individuals responsible alone for the operation of the departments. As pointed out in the chapter on Social Service, the work of the social service departments of these two hospitals is obscured by the dispensary executive responsibilities they carry.

Of the independent dispensaries, the Board of Trustees of the Polyclinic is composed entirely of physicians, an arrangement and in accord with approved standards of board organization. The administrative organization is also not in agreement with the accepted principles of dispensary management, and does not furnish a basis for segregating dispensary costs as differentiated from those expenditures which relate essentially to the operation of its twelve-bed hospital unit, maintained chiefly for private patients.

At Telegraph Hill Dispensary, an activity of the San Francisco Neighborhood Association and managed by its Board of Directors, the executive control of the clinics appears to be carried in part by a member of the board, and in part by a member of the salaried personnel.

In view of the limited service of the Homeopathic Clinic and its small salaried staff, the principles of organization and management applicable to the other dispensaries do not appear to apply.

Dispensary committees of directing boards—advocated in hospital operation as a practical means of dealing with dispensary problems—are undeveloped, Mount Zion Hospital alone having a functioning dispensary committee.

It is evident that in the dispensary field, as in the hospital field, there is need for a general community plan to provide for the special economic and sickness groups to be served. A dispensary committee of the proposed Hospital Council, representing all the organized dispensary groups, would be an effective body to study the particular needs of the city's ambulatory sick, and formulate a program which would co-ordinate the various phases of the work now operating in unrelated units.

SERVICES RENDERED BY DISPENSARIES

In studying the extent of the dispensary service rendered, the main facts considered consisted of (a) the total number of visits for 1922, together with similar data for 1921; (b) the number of new patients applying in two representative months, November, 1922, and January, 1923, and (c) the geographical districts served by the individual dispensaries, based on an analysis of the addresses of 5632 patients applying at the nine dispensaries and the clinics of the San Francisco Hospital during the two foregoing months.

(a) DISPENSARY ATTENDANCE—1922

During 1922, a total of 272,000 visits were made to the nine dispensaries, as follows:

Dispensary Attendance—1922

	Number of Visits	Per Cent of Total	Per Cent Gain or Loss 1921-1922
Hospital Dispensaries			
PUBLIC INSTITUTIONS—			
University of California	90,343	33	+ 1
PRIVATELY CONTROLLED INSTITUTIONS—			
Children's	12,998	5	+ 2
Lane and Stanford University	96,845	36	+12
Mary's Help	11,749	4	+13
Mount Zion	28,520	11	+14
*St. Luke's	11,281	4	+54**
Total	161,393	60	
Independent Dispensaries			
Homeopathic	1,664	1	..
Polyclinic	10,419	3	+37
Telegraph Hill	8,181	3	—32
Total	20,264	7	— 5
Grand Total	272,000	100	+ 7

*Number of visits at St. Luke's includes 5332 visits to Canon Kip Memorial Clinic.
**Attendance at Canon Kip Memorial Clinic not included.

Based upon the foregoing data, the total number of visits to the organized dispensaries during 1922 indicate a ratio of about fifty visits per hundred of population. As the study of the addresses of the new patients indicated that 11 per cent were non-residents. (shown later in this chapter), the actual ratio for the city's population would more nearly approach forty-four visits per hundred.

Comparison of this ratio with the ratios for other large cities is of interest:

Ratio of Dispensary Visits to Population

New York City	(1919)	60 per 100
Chicago	(1918)	35 per 100
Greater Boston	(1919)	50 per 100
Cleveland	(1921)	26 per 100
Montreal	(1921)	45 per 100
San Francisco	(1922)	44 per 100

Using the estimate adopted by dispensary authorities—four visits per patient—it is assumed that some 68,000 persons sought dispensary care, about 60,500 of them being residents of the city.

The percentage of total visits received by the individual dispensary, pictured in Chart G, page 95, indicates the importance of the services contributed by the two university dispensaries, the combined visits to these two institutions representing 70 per cent of the total dispensary attendance of the city for the year. Mount Zion received 11 per cent of the total visits, the other institutions, respectively, 5 per cent or less.

DISPENSARY ATTENDANCE IN SAN FRANCISCO — 1922

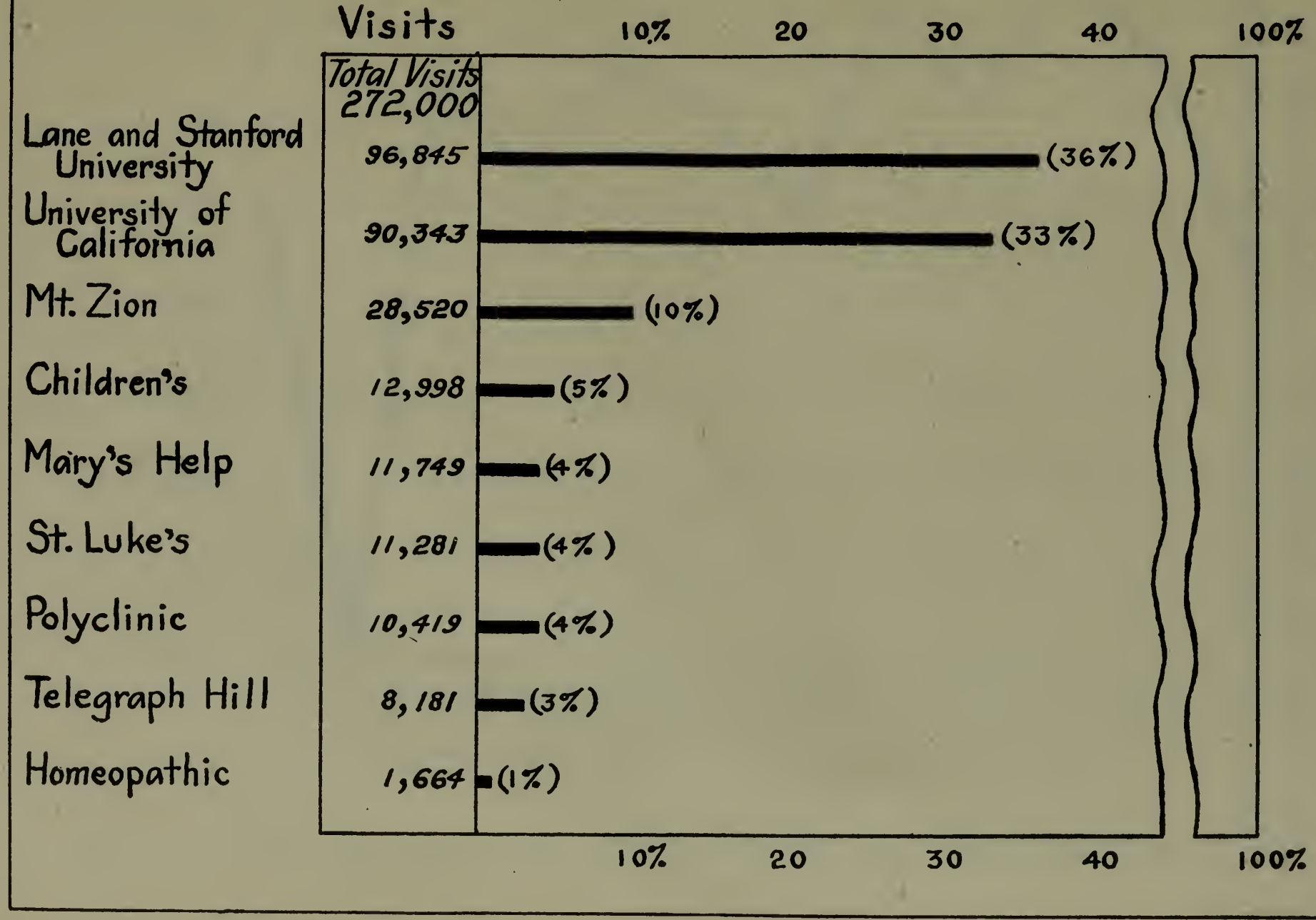

CHART G

The 90,000 visits made to the one publicly maintained dispensary indicate a ratio of 16 per 100 population. The dispensaries under city and State auspices in Buffalo, a city of similar size—650,000 population—during 1922 received 192,213 visits, a ratio of 29 visits per 100 population.

A tabulation of the monthly attendance at the six hospital dispensaries, for the year 1922, indicated only slight seasonal variations in attendance, with the exception of a marked decrease in the number of visits during the month of February. These facts are shown in Chart H, page 97.

SEASONAL USE OF THE SIX HOSPITAL DISPENSARIES
OF SAN FRANCISCO – 1922

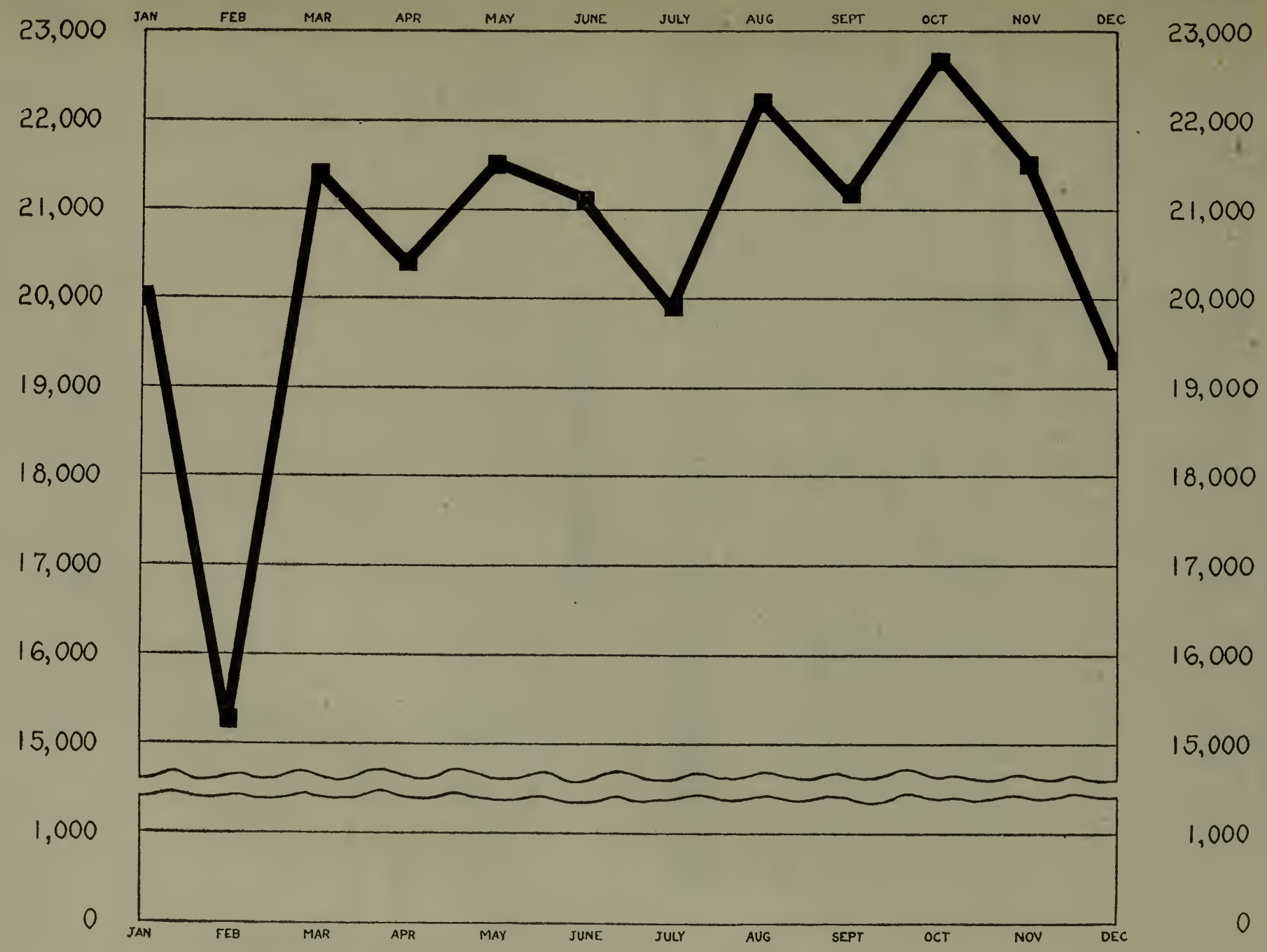

CHART H

The table of attendance also shows the percentage of increase or decrease in visits for the individual dispensaries, compared with similar data for 1921. The total number of visits for the nine dispensaries showed an increase of 7 per cent. Individual dispensaries showed much higher percentages of increase, St. Luke's having an increase of 54 per cent and Polyclinic 37 per cent; the only dispensary showing a decrease being Telegraph Hill, at which the attendance fell off 32 per cent during 1922.

(b) NEW DISPENSARY PATIENTS—TWO REPRESENTATIVE MONTHS

As the number of new patients using a dispensary is one index of the extent to which it is used, tabulations were made of the addresses of the new patients who applied to the nine dispensaries and the clinics maintained at the San Francisco Hospital during November, 1922, and January, 1923, two months considered by local groups to be representative of the maximum monthly demand. This tabulation showed that during these two months 5632 new patients applied for dispensary care, as follows:

New Dispensary Patients—November, 1922, and January, 1923

	Number	Per Cent of Total
Hospital Dispensaries		
PUBLIC INSTITUTIONS—		
San Francisco	249	5
University of California	1712	30
Total	1961	35
PRIVATELY CONTROLLED INSTITUTIONS—		
Children's	340	6
Lane and Stanford University	1920	34
Mary's Help	301	5
Mount Zion	342	7
St. Luke's	196	3
Total	3099	55
Independent Dispensaries		
Homeopathic	49	1
Polyclinic	257	4
Telegraph Hill	266	5
Total	572	10
Grand Total	5632	100

The University of California Hospital and the Chest and Prenatal Clinics at the San Francisco Hospital thus received 35 per cent of the new patients during the two months studied. The privately controlled dis-

pensaries received all told 65 per cent of the new patients, of which the five hospitals maintaining out-patient departments received 55 per cent, and the independent dispensaries 10 per cent.

(c) AREAS SERVED BY DISPENSARIES

The study made of the home addresses of the 5632 new patients was designed to ascertain two important facts, namely, the extent to which the dispensaries are used by residents and non-residents of the city, and the areas served by each dispensary.

The extent to which the dispensaries serve San Francisco is clearly indicated by the fact that, during the two months analyzed, 89 per cent of the new patients were residents of the city, and but 11 per cent non-residents. As shown in the following table, the Homeopathic and the Telegraph Hill Dispensaries received no new patients from out of the city, the University of California Dispensary having the highest percentage of non-residents, 20 per cent of the total. As the last-named is a State institution, it is to be expected that there is at all times a certain percentage of non-resident patients applying for care.

Percentage of City Residents

New Dispensary Patients, November, 1922, and January, 1923

	New Patients	Per Cent from San Francisco
Hospital Dispensaries		
PUBLIC INSTITUTIONS—		
San Francisco	249	97
University of California	1712	80
Total	1961	82
PRIVATELY CONTROLLED INSTITUTIONS—		
Children's	340	92
Lane and Stanford University	1920	91
Mary's Help	301	98
Mount Zion	342	96
St. Luke's	196	99
Total	3099	93
Independent Dispensaries		
Homeopathic	49	100
Polyclinic	257	93
Telegraph Hill	266	100
Total	572	97
Grand Total	5632	89

If the experience of the two months is typical of the usual situation, there is need for a redistribution of the clinic facilities of the city, so that special or acceptable clinic care will be readily accessible to the economic groups for which dispensaries are primarily established.

The present situation is indicated in Map 3, page 101, which shows the large percentage of dispensary patients from the Potrero and Inner Mission districts who traveled long distances to obtain the dispensary care they desired. Thus, only 28 per cent of the 1738 patients went to clinics within the two districts, 60 per cent going to the University of California and Lane and Stanford out-patient departments, the remaining 12 per cent attending the four other dispensaries located on the north side of Market Street.

An analysis of the attendance at the nine dispensaries is of interest as showing the general areas served by the several institutions:

University of California Hospital—Compared with the degree to which it draws patients from other sections of the city, this dispensary serves its own neighborhood to only a small extent. Patients are drawn in large numbers from distant sections; thus, Telegraph Hill, the neighborhood of St. Luke's and San Francisco Hospitals and downtown sections extending from Eighth to Second streets, furnished a large volume of the patients.

San Francisco Hospital—While the majority of the new patients attending the hospital's Tuberculosis and Prenatal Clinics came from the nearby locality, it is of interest that a considerable number came from distant sections of the city, notably Telegraph Hill, where the Neighborhood Association maintains one of the Board of Health Chest Clinics and a Prenatal Clinic, and from the neighborhood of Mount Zion Hospital, which also maintains a Chest Clinic and a Prenatal Clinic, and from the vicinity of St. Luke's, which has no tuberculosis clinic facilities or special service for pregnant women.

Children's Hospital—As the chief center for care of sick children, the dispensary draws patients from nearly every section of the city, with an increased number coming from the Potrero and Sunset districts, and the largest number from the immediate vicinity of the hospital and from the Telegraph Hill district.

Homeopathic Clinic—The new attendance at the Homeopathic Clinic, thirty-nine in all, was too small to be of value. It is significant, however, that one-third of the total new patients admitted during the two months came from the Deaconess Home, which adjoins the dispensary and with which it is loosely affiliated.

Lane and Stanford University Hospital—In addition to a rather general distribution of patients throughout the older sections of the city, the dispensary serves definite districts, large numbers of patients coming from the sections north of Market street, the district bounded by Eighth, Channel, Market, and Second streets, and from the near neighborhood of the hospital.

Mary's Help Hospital—Mary's Help dispensary is furnishing care primarily to its own district, a maximum number of new cases coming from the immediate neighborhood of the hospital.

Mount Zion Hospital Dispensary—The dispensary maintained at Mount Zion also shows a fairly well-defined neighborhood service as,

DISTRIBUTION OF 1738 NEW PATIENTS ADMITTED TO THE DISPENSRIES OF SAN FRANCISCO FROM THE POTRERO & INNER MISSION DISTRICTS DURING NOVEMBER 1922 & JANUARY 1923

MAP 3

except for a few scattered patients in other sections of the city, the new patients came from the immediate vicinity of the hospital and the section bounded by Market, Larkin, Geary, and Fillmore streets.

Although no study was made of the area served by San Bruno Health Center, it was understood that the service is primarily to residents of the locality.

St. Luke's Hospital—The area served by St. Luke's is largely confined to the immediate vicinity of the hospital, only occasional patients coming from other districts. This is particularly of interest in view of the hospital's endeavor to establish the dispensary as a health center for its neighborhood. No study was made of the area served by the Canon Kip Memorial Clinic.

San Francisco Polyclinic — Based upon the addresses of the two months, the Polyclinic's new patients came from the scattered sections all over the city, with a concentration of cases from its own neighborhood and that of Telegraph Hill.

Telegraph Hill Dispensary—This dispensary, the undertaking of a neighborhood settlement, shows the highest percentage of neighborhood service, 96 per cent of the new patients coming from its immediate surrounding district.

DISPENSARY PLANTS

Due to the recent rapid growth in dispensary service and attendance, there is throughout the country a general inadequacy of physical facilities for dispensary care.

In San Francisco, as in other large cities, few of the dispensaries are suited either in original plant or arrangement of space, to meet the demands of modern dispensary operation.

At Mount Zion the dispensary department is housed in a building of comparatively recent construction, planned for the purpose and well-equipped, but its operation is handicapped by overcrowding. The Polyclinic building, while planned for dispensary purposes, lacks essentials in arrangement of space, convenience of facilities, and needs additional equipment to facilitate the work.

The dispensary departments of the University of California and Lane and Stanford University Hospitals, notwithstanding much special equipment and many unusual facilities, are conducted under physical handicaps, the latter especially presenting a picture of compromise arrangements, insufficient space, and awkward working conditions.

The quarters at Mary's Help, Children's, and St. Luke's Hospitals do not provide essentials as to space and arrangement. Mary's Help appears to need additional equipment for special services, the dental facilities being a striking exception. Children's, while excellent in equipment and ingenious in use of space, is conducted in limited and unsuitable quarters. St. Luke's operates under hampering physical conditions, likewise

Telegraph Hill, although a resourceful use of space at the latter lessens the obvious inadequacies of the original plant.

The method of operation in effect in practically all of the dispensaries, with from 77 to 100 per cent of the scheduled sessions occurring in a few hours of the day, emphasizes the original physical defects.

From a community service viewpoint, the chief defects of the dispensaries—prolonged waiting and overcrowded clinics—result from this fact. It should be stated that in no instance was prolonged waiting for clinic treatment regarded by the dispensary workers interviewed as a defect of service. A two-hour wait was stated to be common, and was viewed as a natural phase of dispensary operation.

In particular, recognition should be given to the constant difficulties which confront the work of the dispensary and medical staffs. Cramped quarters, long and crowded clinic sessions, inadequate and inconvenient waiting and dressing-room facilities for patients, constitute working conditions far from ideal.

Taken as a whole, in view of the growing recognition of the community worth of dispensary services and the continued increase in the dispensary activities of the city, the physical conditions in the institutions suggest that (a) a reorganization of clinic schedules is indicated, (b) a rearrangement of space is needed, and (c) additional space is highly desirable.

The limitations under which most of the work is conducted necessitate compromise on the part of the working and medical staffs. The daily impact of large numbers of patients of all types and ages places a tax upon dispensary workers even when there is ample space, suitable arrangements, and specially planned facilities. Judging by the experience of other dispensaries, there is a cost of slow dispensary service to both patients and workers. Factors related to working environment which are receiving increasing attention in the business world, appear equally important in undertakings such as dispensaries, in which the business is to serve human beings and in which the volume of work indicates a steady increase in demand.

DISPENSARY FINANCES

Insufficient information was furnished to permit of any analysis of dispensary finances. It is not known how much is expended for dispensary care in San Francisco. The accounting systems at most of the larger hospitals yield such facts, but it appears that the accounts of the smaller hospitals and of organizations other than hospitals maintaining dispensaries as one of their activities, are not so kept as to furnish these data.

It is obvious that the cost of dispensary care should be analyzed with the same detail as the cost of service in hospitals, i. e., by economic and medical classification of patients.

The importance of the preventive functions of dispensaries, as well as their services to the sick, requires more careful record of facts and analysis

of administrative and medical services than has been undertaken anywhere in San Francisco.

The opinions of the medical profession in regard to dispensary care is expressed in the following quotations from letters of physicians replying to inquiry regarding (a) the need for more dispensary service of any kind, and (b) the adequacy of the present precautions taken through social service or otherwise to prevent the abuse by patients of free medical care:

"There is a lack of co-operation between the various departments of the existing dispensaries. Reports are rarely rendered to the physicians sending patients to the dispensaries for diagnosis."

"There is need for more efficient collaboration between the medical services within the clinics in teaching and research, in order that there be more efficient prevention of disease and treatment of the sick."

"The restriction imposed by the very limited 'free bed' accounts hamper the care of the sick. The sums available for free care are used to supply medicines, X-rays, Wassermanns, etc., leaving almost nothing for free bed care."

"We need more support to improve the quality as well as the quantity of service given. We lack sufficient doctors and are short of nurses and social wrokers."

"Most semi-private dispensaries are lacking in funds to provide special examinations—such as X-ray—and lack the needed space for hospital care of dispensary patients."

"Clinic patients, as in other parts of the country, do not receive careful enough consideration of their condition and complaints—i. e., incomplete histories, inadequate physical examinations, incomplete laboratory investigation, and ill-considered treatment. The difficulty lies in the custom of trying to handle all who come, but also in the training and individual standards of the profession."

"Ambulatory clinic patients frequently require hospital attention and are unable to get it on account of lack of necessary funds. I refer to such cases as require but a few days of bed care and to such as do not wish to go, or should not go, to the San Francisco Hospital."

"It is too easy to secure appointments on our out-patient clinic staffs, and the work of the men in the clinics is not adequately systematized."

The medical opinion was emphatic regarding the inadequacy of the precautions taken to prevent dispensary abuse, there being almost unanimous opinion to the effect that due precautions are not taken. To quote:

"I believe that at our own clinic fully one-half can afford moderate hospital and doctor fees."

"I personally feel if the clinics would look up the financial status of more of their patients, there would be adequate room, and more time and attention could be paid to deserving poor."

"Many clinic patients can well afford private care."

"Social workers of free clinics seldom investigate financial status of applicants, with exception of Children's Hospital."

"I do not believe that adequate precautions are taken, but it is better to serve the unworthy than to neglect one worthy."

"Either precautions are not taken or else the free clinics desire such a large

turn-over of patients (as for student instruction) that all comers are received, without bothering about their financial status."

"Not enough investigation is made of the income and finances of a patient applying for free treatment. People who can well afford to pay a private physician are receiving free medical and surgical care."

The opinions of those connected with the non-medical social agencies emphasize the need for increased financial support for dispensary departments. The belief appears to be general that adequate social service, stenographic and clerical staffs are especially needed to provide the most desirable quality of dispensary care.

Chapter 3

HOSPITAL SOCIAL SERVICE

Hospital social service in San Francisco is provided by six of the ten hospitals. Of the two public institutions, one, the University of California Hospital, has a social service department; that at the San Francisco Hospital has other functions and is not here included in the social service resources of the city. Of the privately controlled institutions, five have established departments—Children's, Lane and Stanford University, Mary's Help, Mount Zion, and St. Luke's Hospitals.

Combined, these six departments have a total of twelve workers, including social workers and nurses, two of them having one worker, Mary's Help and St. Luke's Hospitals, the majority of the workers being attached to the departments of the two university hospitals.

As in many other cities, social service has developed largely through the initiative and stimulus of non-medical and non-hospital groups. In San Francisco the establishment of the work and its continuation and growth have been chiefly due to groups of women who, prior to the joint financing provided by the Community Chest, raised the funds needed and who continue to supply much volunteer service to the work of many of the departments.

The functions of the social service departments in the six hospitals range from the mere giving of relief and investigating patients' ability to pay for hospital or medical care, to the most modern type of medical social service.

In the opinion of both physicians and social workers, there is an undue amount of time and attention now devoted to the question of financial investigation, clerical work, and the handling of out-patient departments, with the result that social assistance which should be available for attending staffs is much reduced.

A study of the reports of the departments and contact with those in

the work emphasizes the disproportionate amount of attention which is directed to work which is not properly medical social work.

As social service is a new element in the hospital family, its position and functions are not as yet universally recognized, with the result that in many communities the work is still undeveloped as either an integral part of hospital care, or as a general community resource for handling community medico-social problems.

The primary function of medical social service—assisting in the medical treatment of the sick—is largely obscured in San Francisco by the fact that the work of the social service departments includes the executive control of dispensary departments, and by the extent to which departmental attention is focused on financial investigation, determining the ability of patients to pay, clerical detail, etc.

Social service does not factor in medical care for the purpose of finding out what patients can pay, nor for the sake of helping to run outpatient departments. Its special work is to furnish information and assistance to physicians for their guidance in the treatment of their patients. In supplying these it collects, evaluates and interprets facts regarding environmental, occupational, and family conditions, including the ability to finance sickness without worry and anxiety.

There is considerable difference of opinion among hospital social service workers regarding the extent to which social service departments should collect financial data, but it is increasingly recognized as part of the administrative detail properly belonging to admitting offices, and not a function of a department assisting in medical care.

For an institution wishing to protect its attending staff and contributing public from imposition by persons who are financially able to meet the cost of their care, the necessary investigations should be made, but it is not necessary to use a medical social worker to obtain these facts. The work appears to fall to social service because, as hospitals are organized today, no others within the hospital organization possess the requisite knowledge regarding standards of living, family budgets, dependency, etc., necessary to make just decisions.

The physical quarters provided for the departments in the six hospitals are generally inadequate and furnish no, or only limited, opportunity for interviewing patients in privacy, a facility regarded as essential to successful social work.

The opinions of physicians and those connected with the non-medical voluntary agencies reflect the fact that more workers are needed in the hospital social service field in San Francisco. To quote opinions on the subject:

"We need competent and trained paid social workers who understand family problems, to follow up patients into their homes and see that the medical treatment they need is carried out."

"I feel that case study is not done well enough. Under the head of medical

social service, the work is essentially economic decisions rather than medical social service."

"There is a need for better organization, less financial investigation and increased workers. These would permit concentration on medical problems, follow-up, etc."

"There is excellent co-operation between the medical and non-medical social agencies, but the limitations imposed on the social service departments make it almost impossible at times to get patients admitted to the right institution. It is undeniable that the work of the hospital's social service departments are hampered by the lack of facilities which should be available. I refer to home nursing service and facilities for convalescents and chronics."

"If the social service workers could devote their time to medical follow-up and similar social service work, instead of keeping accounts and managing clinics, we could do better work for a greater number of patients. They do all they can and are devoted, but their work is organized poorly."

The extent to which social service is used by the various medical services of the several hospitals is not shown in the department reports. There appears to be, however, only small reference of ward cases by members of the attending staffs. Except for the few services which have their own social workers, most of the ward patients coming in contact with social service appear either to have been previously known to the departments, or to have been discovered through personal visits of workers to wards—indicating the need for a more clear-cut hospital and medical staff policy regarding the utilization of social service.

The need for a more active reference of ward patients was clearly demonstrated during the visits to recently discharged patients. Case after case presented problems which could have been met if the social service resources of the hospitals had been utilized, but which only became known through the accident of the Survey. To cite some of the situations found:

Case No. 19—One hospital, which has the proper machinery for referring its ward patients to its dispensary and social service departments, appeared to have overlooked the question of follow-up and social service supervision in the case of a mother who had been a free patient in the wards for almost a month for a rectal operation. The father is a junk dealer and the family poor. There are five children, the oldest 15 and the youngest a baby of three months. When visited three weeks after leaving the hospital, the patient was miserable and was doing the housework for the entire family. She had received no instruction when discharged from the hospital, the baby was sickly, but the patient was not well enough to carry it to the dispensary. The case presented a picture of a sick mother returning to a home of poverty to take up the burden of caring for a family of seven—most of them young children. Lacking instruction as to her further care and unable to adjust home conditions so she could go to the dispensary, she was helpless and despondent. She needed the guidance and friendly interest of a visitor in her home (preferably one who had seen her in the hospital and had established friendly relationships), if not financial aid to tide her over the period of her home convalescence.

Case No. 20—This is a case of a family in which both the man and his wife were ill. He had been in the hospital for five days with acute tonsillitis and peritonsilar abscess, his wife having been previously in the hospital for a week with a throat condition, had returned home the day her husband entered the institution. When visited his physical condition was poor. He was miserable and in need of dispensary supervision, but as he worked from 7 in the morning

to 7 at night, there was no clinic which he could attend in his free time. A washer in a garage, he was worried about his job, as he had been threatened with discharge because of his absence from work while sick, although his employer had decided to give him less money and keep him. This family is able to meet its ordinary financial responsibilities. The husband makes $4.25 a day, paid $21 for his wife's stay in the hospital and $15 for his own care. This evidently took most of the family savings, for when visited they were having a very hard time and did not have a cent in the house, although $17 was owing them. The case was reported to the social service department of the hospital, which took up the matter with the man's employer, who readily made arrangements for the patient to have all the time necessary to attend the dispensary. It was evident that all they needed was a little assistance and friendly interest to right their situation, for they disclaimed any need for financial relief as long as the husband was working.

Case No. 21—The patient, a middle-aged woman, had been in the hospital two days for treatment for cancer, paying $2.50 a day. She had been previously in the hospital for nineteen days for similar treatment in the preceding month, her hospital bill at that time amounting to $50. Her condition is so serious that she will soon be in need of care in an institution for the chronically sick, for she cannot be cared for at home, as the family consists of her husband, two grown sons and a child of nine. The father is the sole wage-earner, making $3.25 a day. The two sons—one a fireman and the other a machinist—do not work because "one is nervous and the other has a hernia." This case presents problems calling for very special assistance. Provisions will soon have to be made for the patient, as her condition is progressively serious and she could not receive the treatments she needs at the hospital of the Relief Home. In addition, a study should be made of the family with special reference to the claimed disability of the two sons, and of their responsibility regarding payment for their mother's medical and hospital care.

Some of the families visited presented health and social problems requiring close co-operation between medical and non-medical agencies. That this co-operation does not always exist appears to be due to inadequate provision for social service, as reflected in the following cases:

Case No. 22—The patient was a baby of 21 months, a part-pay patient in the hospital one day for tonsillectomy. The family, deserted by the father and supported mainly by State and private funds, consisted of three children, the oldest under the supervision of the clinic for a misplaced hip due to bone trouble, the patient, an abnormal baby who, though nearly two years old, did not yet walk, and a five-months-old baby, apparently well. A feeble-minded uncle comes daily to assist with the housework, an aunt also occasionally assisting. The patient had a skin condition that needed immediate medical attention, and was referred to the hospital's clinic. There had been no follow-up from the hospital, which has but one social worker.

Case No. 23—A patient, a man of 31, a lumberman by trade, had been ill a long time, his present stay in the hospital lasting three months. Both of his legs had been broken above the knee two years previously and he has not been able to get around since. The bones were not properly set at the time of the fracture and the patient was in bed thirteen months. His present hospital treatment had consisted of bone grafting. He was receiving excellent care at home, was being visited by his surgeon or assistant, and was still in a body cast. His wife was intelligent and everything for his comfort and improvement was being done. There was, however, a question as to the favorable outcome of the operation. This type of case, bedridden for so long a period, is the type for which occupational therapy has proved highly beneficial. The interest and assistance of the hospital and of his doctor are evident, the hospital making a charge of $1 a day and waiving or materially reducing extra charges. The beneficial results of occupational work as a factor in returning the long-term patient to

usefulness suggest the advisability of such treatment. The question of the favorable outcome of the present treatment also suggests the advisability of a definite occupational program, with reference to possible vocational re-education. The hospital has no social service department, so close working relationship with the more specialized social groups is not established.

The three fundamental principles as to organization, function and policy of social service departments advocated by the National Committee on Hospital Social Service of the American Hospital Association, in its report [8] of a survey of social service in Canada and the United States, are:

1. That the department be organized as a department of the hospital with its head worker responsible to the superintendent or chief executive officer of the institution, and that it have its own budget.

2. That there be a social service advisory committee appointed by the governing board which should meet regularly and which should include representation of the board and the staff, social workers in the community, non-professional men and women, the superintendent of the institution and the head worker of the department.

3. That the department carry on educational work for such groups as social workers, student nurses, medical students, etc.

As to the first, the head workers of the departments are responsible to the superintendent, but few of the departments operate on a budget basis.

As to the second, none of the hospitals have advisory committees constituted as outlined, although many of the individual workers feel the need for closer contact with staffs, outside social organizations and other institutions, and would welcome such committee guidance. It has been the experience in other localities that co-ordinating committees organized along the broad lines suggested anticipate misunderstandings, reduce duplications and familiarize staffs and boards with community problems as well as with questions relating to hospital care and service.

As to the third fundamental, the small extent to which the educational opportunities of the departments are being utilized, suggests that the developments in this regard do not approximate those in other medical and nursing educational centers. The effective utilization of some of the departments is hampered by lack of space and insufficient staffs.

Only a few student nurses and some of the medical students attending Stanford Medical School have the opportunity to learn at first hand, under trained workers, the relationship between medical and social problems. Case conferences as conducted for Harvard medical students with social workers or members of the attending staff of the Massachusetts General and Children's Hospitals; visits made by medical students with workers to the homes of patients, as at the University of Indiana; lectures to medical students by the head of the social service department, as at Washington University and the University of Minnesota, are instances

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8 Bulletins Nos. 23 and 24, American Hospital Association.

of the opportunities provided at other universities. The social service experience of the Stanford students is an excellent beginning, but it is apparent that of the hundreds of medical and dental students and student nurses coming within the influence of the two leading universities of the Pacific Coast, few receive planned experience in a subject so vital to their professional equipment.

Social Service at the San Francisco Hospital

Social service at the San Francisco Hospital is essentially an administrative matter—the determination of the civil and economic right of patients to admission to the hospital.

Although there is an increasing effort to co-operate with the private social and medical agencies, the organization, number of workers and the functions of the department are not planned for medical social service work.

In consequence the hospital care is frequently incomplete and preventable hardships and unnecessary misery are permitted to exist.

The need for an adequate social service department at this hospital, conceived as an adjunct of medical care, was the striking fact brought to light through the visits to fifty discharged patients during the convalescent study. To cite but a few of the cases for which social service was indicated, we can quote the following reports made by the investigators for the Survey:

Case No. 24—A young father and mother, with a baby of 18 months and one ten days old, were found struggling against discouraging odds. The financial conditions were serious, the family living in three very poor rooms and the father out of work. He had been operated upon in the hospital for mastoiditis and was still returning for dressings. The mother was endeavoring to do all the housework, although recently back from the hospital herself and in need of post-natal supervision. The family was reported immediately to a relief agency for financial assistance, the man was referred for suitable employment to the workers then making a study of handicapped persons, and the mother referred for dispensary care—all services which are commonly handled by a hospital's social service department.

Case No. 25—A young man in the hospital for a month for an operation for the removal of a foreign body in the abdomen which had been followed by abdominal fistula, was in need of special assistance to find suitable employment. He had had nine operations and much sickness, had become deaf following an attack of measles, and had had empyema following influenza. A few years ago he had been operated upon for appendicitis, following which he developed a hernia, for the correction of which he had undergone two operations, the last for the removal of some bismuth which had become imbedded in the intestines. When visited he still had a slight discharge from an abdominal wound and he was going to the hospital every day for dressings. Although he was improving steadily in his general health, was most appreciative of all the work which had been done for him, and eager for employment, he was still weak and was in need of occupational therapy and of special assistance to find suitable work, handicapped as he was by deafness and the debilitating effects of prolonged sickness.

Case No. 26—Particularly pathetic was the case of a single man of 68 with pernicious anemia, who was in the hospital over a month. He was without

money, drifting from lodging house to lodging house, wandering around office buildings looking for work. He was referred by the visitor for the Survey to the workers conducting the study of the handicapped, for possible occupational placement, or if his condition prevented his working, for admission to the Relief Home.

Case No. 27—The home environment and facilities for the after care of a little boy who had a tonsillectomy operation were ill suited to his needs. The family, in addition to the patient, consists of the father, who is a printer and is employed all day; the mother, employed from 9 a. m. until 2 p. m., and a child of 10. The children are left in charge of a cousin of 11 years of age and an uncle who comes in for lunch. The family takes one quart of milk a day, the patient getting a cup of milk or cocoa daily. He was in poor physical condition. His operation, and also dental work at the Dental School, had been arranged for by the school nurse.

Case No. 28—A young man was visited who had been unable to work for nine months because of an inflammatory bone condition of the jaw, following the extraction of several teeth. Because of his inability to support his family, his home had been broken up, the patient living with his parents and his wife and young baby living with her parents. He had been in the hospital for two months, had gained thirty-two pounds, was able to eat only soft foods, and was going to the hospital daily for dressings. He was in need of special assistance to find the type of work suited to his condition and was referred to those studying the problem of the handicapped worker.

Many additional cases presented both major and minor social and health problems (among them cases No. 9, No. 11, and No. 16, given in Chapter 2), requiring expert social diagnosis and treatment of matters of home environment, employment, poverty, hygiene, and a close working relationship with the attending staff of the hospital and with the various relief and social agencies of the city.

In view of the fact that there is considerable opinion in San Francisco to the effect that a central social service agency or the social service departments of the two university hospitals, could meet the medical social service needs of the San Francisco Hospital, it should be borne in mind that the critical time for a patient as an individual being returned to usefulness, is prior to or at the time of discharge. It should certainly be the aim of the city to provide as completely for the indigent sick by means of all the known supplementary aids to medical care, as private medical practice provides for the private patient. In the latter the physician gives the questions of after-care, convalescence, suitability of occupation, etc., his personal attention. In hospital ward practice the medical social worker as his agent acting on his orders, collects and interprets facts related to similar questions regarding ward patients, upon which subsequent medical care can be based.

The admirable manner in which the problems of financial investigation and medical social service work are handled at the Buffalo General Hospital,[9] a municipal institution, suggests the advisability of a study by the Board of Health of the methods at this hospital, with a view to applying somewhat similar principles and methods at the San Francisco Hospital.

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9 (a) Bulletin Buffalo City Hospital—Routine Admission of Patients and Financial Investigation Incident Thereto, 1922.

(b) Report of an investigation of the Department of Hospital and Dispensaries, Buffalo, New York. Haven Emerson, 1922.

Summary

Much can be said in praise of the accomplishments of the individual hospital social workers, handicapped as they are by insufficient recognition of medical social service and inadequate provisions for effective work.

It is evident that, in the field of medical social service throughout the city, there is much to be done. In particular, an increase of workers is needed so that the departments will be able to do more effective work. The functions of hospital social service must be more clearly understood, primarily by hospital boards and executives.

For these purposes there will be required (a) increased funds, and (b) the establishment of generally accepted standards for the work, specifically relating to the following:

Functions of hospitals social service.

Organization of social service departments.

Organization and responsibility of social service committees.

Educational activities.

Contact with non-medical agencies.

Use of volunteer workers, etc.

The responsibility for the establishment of standards should preferably be the particular work of a committee of the proposed Hospital Council, providing for representation of the social service departments through their respective head-workers, and of social service committees of managing boards, the San Francisco Medical Society, non-medical charities, public health nurse organizations, Department of Public Health, etc.

Chapter 4

VISITING NURSE SERVICE

"The public health nurse is any graduate nurse who serves the health of the community, with an eye to the social as well as the medical aspects of her function, by giving bedside care, by teaching and demonstration, by guarding against the spread of infections, insanitary practice, etc." [10]

The nursing service provided by the various organizations of San Francisco employing public health nurses for visiting in homes may be classified in four main groups:

(a) *Bedside care for general sickness accompanied by health education,* commonly called visiting nursing.

(b) *Bedside care for maternity patients, accompanied by special instruction,* such as furnished by the Stanford Clinics Auxiliary and San Francisco Maternity and the University of California Hospital, for maternity patients delivered at home.

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[10] Nursing and Nursing Education in the United States. Report of the Committee for the Study of Nursing Education, 1923.

(c) *Social follow-up and health instruction of discharged hospital and of dispensary patients, with occasional bedside care,* as supplied by the nurses constituting the staffs of the Children's and Mount Zion Hospitals Social Service Departments.

(d) *Follow-up, education, supervision for special groups, etc., with no bedside care,* as furnished by nurses attached to hospital social service departments, school, tuberculosis and nutrition nurses, etc., attached to the Department of Public Health, nurses employed by health or social organizations, such as the Children's Health Center, Junior League, etc., and those engaged in industrial nursing.

The organizations maintaining the foregoing public health nursing services, together with the extent and character of the service furnished, are:

	Number of Nurses	
(a) Bedside Care for General Sickness Groups—		
Metropolitan Life Insurance Company	4	
San Francisco Neighborhood Association	3	7
(b) Bedside Care for Maternity Patients—		
Stanford Clinic's Auxiliary and San Francisco Maternity	2	2
University of California Hospital	Occasional student nurses	
(c) Social Follow-up, Instruction and Occasional Bedside Care—		
Children's Hospital	2	
Mount Zion Hospital	2	
Schmidt Lithographers	1	5
(d) Follow-up, Instruction, etc., with No Bedside Care—		
Private Organizations		
Associated Charities	3	
Children's Health Center	1	
Junior League	1	
Little Children's Aid	1	
Mary's Help Hospital	1	
Presbyterian Mission	1	
St. Luke's Hospital	1	
St. Mary's Hospital	1	
Stanford Clinic's Auxiliary and San Francisco Maternity	4	14
Public Organizations		
University of California Hospital	2	
Department of Public Health—		
Child Welfare	4	
Juvenile Court	2	
Nutrition Workers	3	
School Nurses	21	
Social Service Department San Francisco Hospital	3	
Social Hygiene	1	
Tuberculosis Home Visitors	9	45

Industrial Organizations

American Can Company	2	
Bemis Bag Company	1	
Bollman Tobacco Company	1	
California Candy Factory	1	
California Packing Company	2	
Emporium	1	
Hale's Department Store	1	
National Carbon Company	1	
National Paper Products Company	1	
Western Sugar Refinery	1	
Western Union Telegraph Company	1	13
		86

From the point of view of financial support, these organizations fall under one of three groups—those supported by public funds, those deriving their support from charitable donations and fees of patients, and those maintained as business enterprises. The following table presents the extent of the public health nursing service provided by each group:

Financial Support of Public Health Nursing

Type of Nursing Service Furnished	Total	Number of Nurses Maintained By Public Funds	By Private Charity	By Business Organizations
(a) Nursing Care and Instruction	7 (8%)	..	3	4
(b) Nursing Care and Instruction for Maternity Patients	2 (2%)	Occasional student nurses	2	..
(c) Follow-up Home Visits, Instruction, etc., and Occasional Nursing Care	5 (6%)	..	4	1
(d) Follow-up Home Visits, Instruction for Special Groups, with No Nursing Care	72 (84%)	46	13	13
Total	86 (100%)	46 (53%)	22 (26%)	18 (21%)

As shown in the foregoing table, 84 per cent of the nurses visiting in homes do no bedside nursing, 6 per cent furnish such care only occasionally, 2 per cent nurse maternity patients (exclusive of the occasional student nurses at the University of California caring for maternity patients delivered at home, totaling less than fifty cases yearly), and but 8 per cent devote practically all their time to bedside care.

It is apparent, then, that what is generally spoken of as visiting nursing—sometimes called district nursing—is provided in San Francisco by the three nurses attached to the San Francisco Neighborhood Association and by the four nurses of the Metropolitan Life Insurance Company.

Public health nursing, as represented in the instructive and special follow-up nursing services of the Department of Public Health, is well

developed. The same is true regarding other phases of health education work provided by the nursing staffs of various private organizations specializing in health and public welfare activities.

Visiting nurse care of the sick in their homes is obviously so undeveloped as to be practically non-existent.

That a city of 540,000 population has available for visiting nurse care in homes but seven nurses, four of whom are only available for the policyholders of an insurance company, indicates a meager development of one of the outstanding services for modern care of the sick. This is particularly the case, in view of the fact that the visiting nurse is today ranked as one of the most valuable elements in health work, because of the unique and intimate place she occupies as the family health educator.

San Francisco's lack of development of this service is unusual. No other city of its size in the country lacks this service. The number of public health nurses, and of these the number giving bedside care in the eight cities of the United States ranging from 400,000 to 600,000 population, is as follows:

	Population 1920 Census	Total Number of Public Health Nurses *	Number of Public Health Nurses Giving General Bedside Care
Pittsburgh	588,343	112	78
Los Angeles	576,673	64	40
Buffalo	506,775	83	46
San Francisco	506,676	40	3
Milwaukee	457,147	90	26
Washington	437,571	54	26
Newark	414,524	80	13
Cincinnati	401,247	55	16

*Exclusive of industrial nurses and those employed by social service departments.

With so limited a visiting nurse service, it was natural that many of the cases visited showed a need for nurse follow-up to see that doctors' orders were being carried out, provide instruction as to diet, hygiene, health promotion, etc. A few of the patients needing such nursing care may be cited:

Case No. 29—The young mother of four children, a colored woman, was a free patient for six weeks in one of the hospitals, with diabetic gangrene, which necessitated the amputation of a first finger. When visited she was going to the dispensary once a week for dressings and was following the diet instruction given by the doctor at the hospital. The patient returned home to do the work for her family, the youngest a baby only a few months old. The home was crowded and untidy, the older children trying to help with the housework. This patient was in urgent need of the service, supervision and stimulation of a visiting nurse, to instruct and assist her in preparing her diet and to assure the continuance of her dietary treatment.

Case No. 30—A patient was in one of the hospitals for five weeks following an operation for uterine tumor. When in the hospital the incision broke open eight days after the operation, necessitating a second operation under anesthesia. As she was considerably nauseated after the second operation, the doctor could not be certain that the inner stitches held. On discharge the patient was told a possible hernia might develop in the wound, if at all, within the next few

months. No attempt was made by the hospital to keep in touch with her, and no instruction was given as to the proper course for her to follow during the period while waiting for the possible hernia to develop.

Case No. 31—Visiting nurse care would have met many of the needs of a child of 3 who was sent home after a ten days' stay in the hospital for tonsillitis, with a bad cough and running nose, no instructions being given her mother regarding any home care. Other children in the hospital had measles, and ten days after the patient came home she also developed measles. The child had a persistently poor appetite and a succession of colds, but the mother had had no instruction regarding upbuilding care or the special supervision needed.

Case No. 32—A boy of 4 was for four days in one of the hospitals which has a social service department—diagnosis: tonsillitis and otitis media. The parents paid 50 cents a day for his care. The visitor for the Survey states: "If a visiting nurse had been sent to this home for follow-up care the inadequacy of this family to follow the instruction given would have been known." The family was in great need. They had been in California only a few months, and the father, a shoemaker by trade, had only been able to get work for a day or two a week since his arrival. There were three children, the oldest 4 and the youngest 1½ years old. The mother, five months pregnant, did not know where to go for care. She was referred by the visitor for the Survey to an agency for financial aid to tide them over their period of trouble and to a prenatal clinic. Even the $2 charged by the hospital must have been a tax on a family so handicapped by unemployment and lack of money.

It is judged that a visiting nurse service, in view of the small amount of dependency in the city, would be at least two-thirds self-supporting. The experience of other cities in this respect, presented in an authoritative report[11] of public health nursing in the United States, is of interest:

Proportion of Patients Paying in Full, in Part or Not At All, for Visits from Thirteen Privately Supported Visiting Nurse Associations During the Year Preceding This Study*

Number and Type of Organization	Per Cent of Patients Visited Free	Per Cent of Patients Paying for Visits		
		Total	Paying in Full	Paying in Part
Urban:				
1	100.0	....	....	....
2	100.0	....	....	....
3	100.0	....	....	....
4	100.0	....	....	....
5	42.6	57.4	36.3	21.1
6	39.5	60.5	45.2	15.3
7	37.6	62.4	57.3	5.1
8	31.0	69.0	46.9	22.1
9	27.2	72.8	43.9	28.9
10	25.0	75.0	10.0	65.0
Rural:				
11	2.0	98.0	94.4	3.6
12	35.6	64.4	**	**
13	99.4	0.6	0.6	....

*These figures are based on reports submitted by these organizations. Visits made for the Metropolitan Life Insurance Company were counted as full pay visits. These were included in four urban societies' reports.

**Distinction between those paying in full and in part was not made in report given us by this organization.

11 Nursing and Nursing Education in the United States. Report of the Committee for the Study of Nursing Education, 1923.

Certain of the cases visited indicate that there is at present a demand for visiting nurse care among patients who pay in whole or in part for their hospital care, illustrated in the following:

Case No. 33—A woman of 41, in the hospital for a month, had an operation for cancer of the breast so extensive and severe that she had to have a blood transfusion. Three weeks after discharge from the hospital, when she was visited, she was sleeping badly, her arm was swollen and painful and her appetite poor. She was attending the hospital's dispensary for dressings and physiotherapy treatments three times a week. When she came home from the hospital she was so ill she had been unable to go to the clinic and secured the Metropolitan nurse who came in once to do her dressing. The picture is one of a patient returning home sick and miserable and in need of some nursing care. As she had paid $189.95 for her hospital care, she would have been able to pay for convalescent care in an institution or visiting nurse service at home had either of these been available.

Case No. 34—Another patient expressing a desire for home nursing care, was a woman who had been in the hospital for a little over two weeks for an operation for a breast tumor. Although all the nursing care needed was assistance in taking her bath, getting dressed, combing her hair, etc., as the patient's sister could do everything else for her, she was employing a nurse for twelve hours daily. Her needs could have been admirably met by the services of a visiting nurse for a few hours. The patient expressed the opinion that there was a need in San Francisco for visiting nurse service for which payment could be made on the basis of the time used.

Case No. 35—This case is also of interest as indicating a recognition on the part of a full-pay patient that the services of a visiting nurse would have met all his nursing needs after his return home from the hospital. This patient, in the hospital for five weeks for an operation, was discharged to his private physician. His dressing was being changed daily, and he wished there was a visiting nurse service in the city, so he would not have to get up and go to the doctor's office for dressings.

Case No. 36—A young woman, in the hospital for fifteen days for an abdominal operation, received instructions before discharge regarding subsequent care, but she needed visiting nurse instruction at home to teach her how to carry them out, a service which was not supplied, although many of this institution's discharged patients receive instruction at home. This patient is in the part-pay group, paying at the rate of $4 a day at the hospital, having made arrangement to pay $15 a month until her bill was paid.

San Francisco needs a visiting nurse association to spread the kind of service that is being given by the San Francisco Neighborhood Association on Telegraph Hill to other parts of the community. Provision should be made for visiting nurse service so that bedside nursing can be had on call and at cost by all people who, under medical direction, wish to have it.

The combined opinion of groups concerned with health and sickness problems of the individual and of the community as a whole, is in agreement that this is an essential service which should be provided. The question has received considerable attention, and a representative committee has collected information and drawn up tentative plans for establishing a visiting nurse association.

It is assumed that such a service will be available for all economic groups in the population, and that the practice of withholding all visits, unless there is a doctor in attendance on the case, will be adhered to.

There is ample experience upon which to draw for guidance in determining such details as organization, contact with the medical profession and hospitals, administration, districting, affiliation with training schools for nursing, etc.

On general questions, the National Organization for Public Health Nursing is equipped to furnish counsel and advice of the most valuable character, while the experience of the San Francisco Neighborhood Association would afford assistance in adjusting generally accepted methods to local conditions.

Chapter 5

CONVALESCENT HOMES

The inadequacies of the present facilities for institutional convalescent care in San Francisco are well known to all in contact with health and hospital work. As one social worker said, "The situation is one that confronts every social and welfare worker in San Francisco."

The Council of Social Agencies, through a sub-committee studying hospital problems in 1923, reports: "There is a need for a special committee to investigate the local need for an institution or home for convalescent patients from hospitals, especially the San Francisco Hospital, where convalescent patients could find a temporary home at a minimum cost while seeking employment instead of being dumped into the cheerless cheap lodging-house."

The few facilities for the institutional care of convalescing adults and children consist of the Bothin Convalescent Home at Manor, Marin County, 37 beds; Drexler Hall at Redwood City, 16 beds; and the Stanford Convalescent Home at Palo Alto, 16 beds.

The Patient groups received by the three institutions are as follows:

Bothin Convalescent Home—Receives boys and girls between 5 and 10 years of age for general convalescent care and for preventive care; and women of all ages—the accommodations for women being limited to two beds. It receives both pay and free patients and is not equipped to care for bed cases. Changes now being made will provide ten additional beds for girls and will make it possible to use all the facilities the year round instead of only eight months, as formerly, but make no provision for bed care.

Drexler Hall—Receives girls from 3 to 18 years of age suffering from orthopedic conditions. The institution is maintained entirely from private sources and limits its service to free patients. It is not equipped to care for bed cases.

Stanford Convalescent Home—Receives boys and girls from 2 to 12 years of age, including both pay and free patients, and is equipped to

care for a few bed cases. An admirably planned unit nearing completion will provide facilities for 20 bed cases, 10 boys and 10 girls.

In addition to the foregoing, the Ladies' Protective and Relief Association plans to build a home for aged women within the city limits, which will provide 10 or 12 beds for convalescing women patients, other than bed cases or mothers with infants or young children.

With these additional accommodations, there will be available within about one year, a total of approximately 110 beds as follows:

	Bed Cases	
Adults—Men	....	
Women	....	
Children—Boys	10	
Girls	10	20
	Up Cases	
Adults—Men	....	
Women	12 to 14	12 to 14
Children—Boys and Girls	51	
Girls only	26	77
Total		109 to 111

The obvious inadequacies of these facilities are apparent, as they include no provision for adult male patients, none for bed care for women and only minor provision for up-cases, practically none for mothers with infants, and but few beds for special patient groups and those only for children.

The opinions of physicians, hospital administrators, and social workers expressed to the Survey, constitute a convincing array of informed opinion regarding the inadequacies of the facilities.

The members of the San Francisco County Medical Society gave more attention to the matter than to any of the subjects on which opinion was asked, 62 per cent of the replies testifying to the need for increased accommodations. The special groups for which it was considered provision should be made, according to the number of replies, are:

General Medical and Surgical; Mental and Neurological; Obstetrical and Gynecological; Pediatric; Orthopedic; Ear, Nose, and Throat; Venereal and Genito-Urinary Diseases; Dental; Eye.

A high percentage of the hospitals expressed opinions which indicate a pressing need for facilities for free and part-pay convalescing hospital patients, a few mentioning in particular the need of accommodations for men, mothers with children, and boys over 10.

Other health agencies emphasized the difficulty experienced in obtaining suitable convalescent care for free and part-pay patients, especially men, women, boys over 10, and women with cancer, the last reflecting a rather common confusion of chronic and convalescent problems.

Social service groups co-operating with health agencies were of the

opinion that there is a general need for facilities for all the economic and patient groups.

To quote some of the individual opinions:

"The greatest medical need in San Francisco is for free convalescent care."

"The convalescent facilities are limited to adults—children are taken care of."

"Convalescent bed care is almost entirely lacking and available only for an occasional child."

"Part-pay convalescent care is needed for patients requiring bed care."

"At the present time there are no adequate facilities for convalescent care for adults in San Francisco. The situation in regard to single men needing care during convalescence is really distressing."

"Convalescent bed care is very insufficient, especially for children."

"Free or part-pay convalescent bed care outside of our large hospitals is needed for convalescent children."

The unsuitability of such institutions as the Relief Home for convalescing patients should need no comment. In the opinion of the superintendent of the Home, the morale of the convalescent, particularly the younger man or woman, is permanently injured by association with the aged almshouse or chronically ill type of patient.

The problem of meeting the individual needs of convalescing patients is one touching a wide range of health and social services. It includes private medical practice, hospital and dispensary service, public health nursing, medical social service, convalescent institutional care, vacation camps, rest-homes, etc. Experience has proved that it is only through the intimate co-operation of these services that the most satisfactory results are obtained.

The visits to recently discharged patients indicated that satisfactory convalescence from hospital care is not being obtained in many instances in San Francisco because (a) co-operation among the various services concerned is insufficiently developed, and (b) three important services for supplementing hospital care—medical social service, convalescent institutional care and visiting nurse care in the homes—are inadequately provided for.

Many of the conditions found to exist among the 160 discharged patients visited in their homes, previously described in various chapters of this section, reflect in different types of cases the results of the present inadequate co-operation between certain of the existing services responsible for convalescent care. Additional cases showing the type of case for which institutional care was indicated, were as follows:

Case No. 37—The patient, a single man of about 50 years of age, was in the hospital for a month with heart disease, and when discharged was unable to work, without funds, and dependent on friends who were paying his room and board. He had drifted in to one of the independent dispensaries, instead of the one to which he was referred, and had been referred also to those working on the problem of the handicapped. What the patient needed was care in a well equipped convalescent home providing medical supervision and facilities for suitable occupational placement.

Case No. 38—A mother of 21, in the hospital to be delivered of her first baby, had had a very severe labor necessitating extensive surgical repair. On leaving the doctor told her to take life easy for several weeks, but this was hardly possible, as her husband had been out of work for some time, had only had employment for three weeks and was away working in the country. When the patient was visited, two days after leaving the hospital, she was washing at a tub placed on a low chair so as to work with less difficulty. The patient paid $35 for her hospital care, but her financial and physical condition indicated that she either needed financial relief so that a houseworker could be provided to do the heavy work and she could take life easy as directed by the doctor, or she needed care in a convalescent institution until she was strong enough to resume her normal life.

Case No. 39—A mother of 22 with three children, was in the hospital eighteen days for an operation for chronic appendicitis. On her return home the patient took care of her two youngest children who required extra watching, and did all the housework except that which her husband could help her with after he returned from work, her mother taking charge of the oldest child. It was evident that this patient would have benefited by a stay in a convalescent institution following her operation and should not have been permitted to return to arduous household worries and labors. The hospital charge of $15 a week was low, but high for a family of five supported by one wage-earner making $35 or less weekly.

When convalescent care is not adequately provided for, either at home or in special institutions, waste of hospital service results, due to the fact that patients are frequently discharged from hospitals before they are able to take up the burdens of home and occupation. Avoidable suffering, not infrequently relapses, and often a more or less protracted period of weakness results. With the object of preventing these and similar misfortunes, patients are retained in hospitals for the acutely sick longer than would be needed if suitable facilities for convalescence were available. This is especially true regarding the ward patient, whose home conditions are so frequently unfitted to the type of convalescence needed.

The extent to which long-term patients are held in the hospitals for the acutely sick in San Francisco is indicated by the fact that, of the 1805 patients in the hospitals on June 21, 11 per cent had been in the institutions from 31 to 60 days, 4 per cent from 61 to 89 days, and over 9 per cent for 90 days or longer (shown in Chapter 6 of this section), indicating a total of 442 patients in the hospitals for one month or more. As many of those hospitalized for three months or longer were obviously chronic cases, it is assumed that the 15 per cent in the hospitals from 31 to 89 days—273 patients—represents the convalescing group on this one day.

The experience of the large Eastern cities, where the question of convalescent care has received special attention, indicates that institutional care will be needed for 12 per cent of the total number of hospital patients cared for yearly. Using the 51,840 patients cared for in the ten hospitals during 1922 as a basis, it is estimated that, in San Francisco, some 6000 patients annually require institutional care for convalescence.

During 1922, the three existing convalescent homes cared for a total of 544 patients. As the capacities of two of the homes are being increased by some thirty beds during the current year, it is estimated that the exist-

ing facilities can take care of about 1000 of the 6000 cases needing institutional care annually.

Based upon the commonly used estimate of 17 patients to one bed per year, 350 beds are required for the 6000 patients.

Long experience in the larger cities of the country indicates that these accommodations should be apportioned as follows:

	Beds
Adults—15 years and upwards—General medical and surgical conditions	120
Children—Boys 6-12 and girls 6-15—General medical and surgical conditions, including orthopedic and heart disease	100
Boys—10 to 15 years	30
Mothers with infants and young children (averaging 60 patients)	30
Special facilities for cardiacs	40

With but 110 beds available or even planned for, and lacking provisions for many special patient groups, the facilities are entirely inadequate. In view, however, of the generally high level of living and the relatively small percentage of dependency, it is possible that San Francisco may not need to provide as extensively for institutional convalescent care as the communities on whose experience the estimated number of convalescent beds needed is based.

It may be found expedient to collect information over a definite period, in order to verify or correct the estimates herewith presented. The exact extent to which provision should be made could be determined by a collective study undertaken uniformly in each hospital, such a study to include the collection of medical opinion relative to the particular convalescent needs of individual patients, namely, whether institutional convalescent care, home-nursing care, vacation camp, etc., is needed. These facts, correlated with facts as to the adequacy of the home conditions for the type of convalescence required, would furnish the desired information regarding the particular patient groups for which provision should be made. Thus one of the groups which will require early and special attention is the orthopedic child. The opening of the Shriners' Hospital will probably add considerably to the number of such children needing long periods of convalescent care. The admirable facilities and achievements of Drexler Hall suggest the desirability of similar facilities for boys, and for part-pay patients, both boys and girls.

The convalescent institutions have invaluable first-hand information regarding the special groups for which provision is needed, and could assist considerably in any joint program for the solution of the problem. Their work, conducted with small general recognition of the highly important services they render, is founded on the modern idea that convalescent homes should provide not only medical supervision, but also facilities for upbuilding and education in health habits.

Chapter 6

HOMES FOR THE INCURABLE AND CHRONICALLY SICK

A comprehensive study of the institutional care of the chronically sick has been recently made throughout the United States and Canada in response to a widespread feeling that the problem has not yet received the recognition it deserves. The report [12] briefly states the problem:

"A chronic patient may be described as one who requires hospital care for a period of from three months to several years. From the point of view of institutional care, these patients may be grouped into three categories—Class A, those requiring medical study for diagnosis and treatment; Class B, those requiring nursing care only; Class C, those requiring custodial care only."

The report stresses the complexity of the problem of caring for these various groups and the different types of institutional care demanded, and is clear-cut in stating standards regarding the facilities which should be available for the three groups:

"The proper care of a Class A patient demands a complete hospital organization with a resident staff, an attending staff on which all of the specialties are represented, complete laboratory, X-ray and operating-room equipment, skilled nursing and dietetic management. Class B patients require much less specialized attention, but should command an excellent nursing service, controlled by a conscientious medical staff. Class C patients need the least care. As the classification implies, the treatment of this last group is largely custodial in character. These patients are retained in an institution, not because they require hospital care, but because poverty makes home care impossible. The problem is economic, not medical. All of their wants are supplied with due regard to their respective disabilities by proper sleeping and living accommodations and food."

San Francisco has two institutions planned and equipped for the care of the chronically sick, namely:

(a) Hospital of the Relief Home for the Aged and Infirm, conducted for indigents by the Board of Health.

(b) San Francisco Home for Incurables, a privately controlled institution.

The accommodations and facilities available in these two institutions may be briefly stated:

(a) *Hospital of the Relief Home for the Aged and Infirm*—The Hospital of the Relief Home, with a capacity of 500 beds, accommodates a number of widely different groups, as follows:

	Men	Women	
Arrested Tuberculosis (aged chronic)	25	..	
Cancer	25	20	
Paralytic	60	25	
Aged Chronic	160	45	
Custodial	100	40	
Totals	370	130	500

[12] Dr. Ernest P. Boas, Director of the Montefiore Hospital for Chronic Diseases, New York, and Dr. A. K. Haywood, Superintendent Montreal General Hospital, Montreal, Canada. Modern Hospital, July, 1923.

As the hospital is also the infirmary of the Relief Home, there is a constant interchange of inmates back and forth between the Hospital and the Home units.

The physical condition of the 1244 inmates in the Home and Hospital sections on July 21, 1923, indicates to some extent the complexity of the hospital and custodial problems existing in this type of public institution:

	Men	Women	Total
Epileptic	16	6	22
Blind	29	6	35
Deaf	28	12	40
Mentally Incompetent	71	58	129
Crippled	116	31	147
Bedridden	120	43	163
Able to Work	297	31	328
Old and Infirm	283	97	380
Totals	960	284	1244

Due to the fact that the Hospital and Home statistics are not separately assembled, facts as to the number of these which were hospital patients, were not available. It was stated, however, when the institution was visited, that the patients in the Hospital numbered approximately 300, many of the deaf, blind, and crippled not in need of hospital care living at the Home.

The medical service available for the 300 patients consists of two physicians who attend every morning and are on call at all other times, one of them living on the grounds; specialists being available for consultation when needed. There are no resident physicians or interns. The six medical students who work in the Hospital at night do not serve in an intern capacity, but as orderlies.

The Hospital has no laboratory, all laboratory specimens requiring examination being sent to the San Francisco Hospital. Patients requiring X-ray examinations are sent either to University of California Hospital, but four minutes from the institution, or to the San Francisco Hospital.

The nursing of bed patients is performed by aged inmates of the Home, working under the direction of nine trained nurses.

The planning, preparation and service of food is not under the supervision of a trained dietitian.

There is no social service department.

As no separate records are kept for the Hospital section, there was no information assembled which would indicate the number of sick receiving hospital care, the medical conditions cared for, results, etc.

The statistics for the fiscal year ended June 30, 1923, which reflect to some degree the sickness problems involved, were as follows:

Admissions—1922

	Men	Women	Total
Through Board of Health	613	157	770
From San Francisco Hospital	259	78	337
By Superintendent (readmissions)	31	8	39
Totals	903	243	1146

Discharges—1922

	Men	Women	Total
At own request	403	114	517
Died	249	118	367
Left without permission	105	5	110
Overstayed pass	55	7	62
Sent to San Francisco Hospital	48	7	55
Sent to State Hospital	13	8	21
Sent to Tuberculosis Hospital	7	0	7
Totals	880	259	1139

Ages of Inmates—1922

	Men	Women	Total
20 to 30	9	0	9
30 to 40	26	3	29
40 to 50	51	20	71
50 to 60	143	42	185
60 to 70	300	88	388
70 to 80	312	74	386
80 to 90	109	51	160
90 to 100	10	6	16
Totals	960	284	1244

Average age of inmates, 66.88 years.

Deaths—1922

	Men	Women	Total
30 to 40	3	2	5
40 to 50	10	4	14
50 to 60	34	14	48
60 to 70	75	36	111
70 to 80	92	38	130
80 to 90	34	22	56
90 to 100	1	2	3
Totals	249	118	367

The financial report of the institution shows a total per capita maintenance cost for inmates of $.706 a day, made up of the following cost units:

Unit Costs—1922

Subsistence	$.245
Tobacco	.014
Clothing	.025
Fuel	.037
Drugs, Medical and Surgical Supplies	.014
Miscellaneous Items, new equipment, repairs, etc.	.143
Total	$.478
Payroll, employes	.179
Payroll, inmates	.049
Total	$.706

Compared with standards of care quoted earlier in this chapter, the facilities maintained by the city for its indigent infirm and chronically sick suggest the need primarily for increased expenditure of funds to provide better hospital standards. With no separate costs available for the hospital, the per capita amount expended for the care of the sick is not known, but the observations of the Survey and the opinions of local social workers familiar with the conditions, force the conclusion that the city has not been liberal in the amounts allowed for hospital maintenance and medical and nursing care at the Relief Home. It was understood that the immediate expansion definitely planned for at the institution does not include changes in the hospital, but that a program for increased facilities for the sick at some future date not yet determined has been arranged.

(b) *The San Francisco Home for Incurables*—The San Francisco Home for Incurables admits full pay, part pay and, in some instances, free chronically sick patients, including both bedridden and ambulatory cases. Patients requiring hospital care are not received, as the institution is not equipped to care for them.

The Home has a capacity of thirty-nine, as follows:

	Beds	
In wards for women	4	
In wards for men	5	
In double rooms	10	
In single rooms	20	39

The conditions received are mainly paralysis, senility, arthritis, etc. Patients with disturbed mental conditions, drug addicts, and alcoholics are excluded.

The turnover of cases is low, as there were only 34 admissions during 1922. There were 29 discharges, 16 of them deaths.

The institution has a high percentage of use, and is adding a new wing providing eight rooms for the use of women with incurable or non-

operative cases of carcinoma, and similar accommodations for men are to be constructed in the near future. The experience of the Home indicates there is at all times a demand for beds, on an average of three cases a week being refused because of lack of room. It is the opinion of those connected with the Home that at least forty more beds could be used, if available.

The institution is maintained at a per capita cost of $2.40 a day, but the financial data furnished were not sufficiently complete to permit of analysis.

The arrangement and equipment of the building and the directing policies reflect excellent management. It is believed that the publication of an annual report of the institution's activities would awaken further interest in the problem of the care of the chronically sick.

The opinions expressed by many physicians, nine hospital executives, and over two-thirds of the health and social workers replying to direct inquiry on the subject, appear practically unanimous regarding the inadequacy of the facilities afforded by these two institutions. A few of these opinions, herewith presented, indicate that the subject offers definite problems, as follows:

"The care of the aged and infirm is a decided problem, due to the inadequacies of our institutions and the lack of visiting nurse care in the homes."

"The Home for Incurables provides a very excellent service for those who can pay a moderate amount. Reduced rates are given to certain patients, but the accommodations of the home are very limited. The service for chronic patients at the San Francisco Relief Home does not meet the standard of the patients nor their friends. The city has not provided the money necessary to maintain hospital service, and patients transferred from the San Francisco Hospital to the Relief Home feel very bitterly the change of standards. There is the greatest need for the development at the Relief Home of a hospital for chronic cases with hospital standards, with a medical staff, adequate nursing facilities and diet that is appetizing and tempting to those who are chronically sick. It is believed that the Supervisors and people of San Francisco would willingly pay the cost of such a standard if those who are directing the social work of the city make an organized demand for it. It has, however, been fallaciously assumed that money for this purpose would be provided at the expense of money needed for curable patients who were acutely ill. There is, however, no question that the need of the curable patients should have precedence, but in a community as wealthy as San Francisco there is no reason why both should not be provided for. There is a special need for the development of proper care for incurable cancer patients. From our experience, I believe a study of the situation would show that the majority of hopeless cancer patients discharged from San Francisco Hospital referred to the Relief Home, refused to go there and either return to rooms in lodging houses or to their own homes, where they cannot receive the care they need, especially in the later stages of disease."

"In regard to facilities for chronically ill who could afford to pay, I believe that there is need for additional facilities at a moderate price. What is really needed is a semi-charitable home where people of small means can care for their chronically ill, at, say, not over $50 a month. There is nothing in San Francisco today that meets this problem."

"Institutional care for chronic patients is inadequate for free and part-pay patients, particularly for cancer cases."

"Institutional care for chronic patients is practically lacking for those who can pay."

"The placing of the totally blind who are without funds and cannot follow their former vocation owing to their physical debility is most difficult."

The result of insufficient or inadequate facilities for the chronically sick is commonly shown in the extent to which beds in general hospitals are used for long-term patients—that is, patients remaining for three months or more.

The census of June 21 showed an extensive use of the hospitals for long term patients. Of the 1805 cases, some had been hospitalized from five to ten years and over, and many for more than a year. As shown in the accompanying table, 169 patients—9 per cent of the total number—had been in the hospitals three months or longer:

Long Term Patients in General Hospitals*—June 21, 1923

Time in Hospitals	Patients		Age		Sex		Rate of Payment		
	No.	Pct.	Adults	Children	M.	F.	F. Pay	P. Pay	Free
10 to 15 yrs.....	2	1	..	2	..	2	..	..	2
5 to 10 yrs.....	2	1	1	1	2	..	..	..	2
1 to 5 yrs.....	41	24	26	15	22	19	13	10	18
8 mos. to 1 yr..	17	10	13	4	12	5	5	1	11
4 to 8 mos.....	66	40	48	18	39	27	28	11	27
3 to 4 mos.....	41	24	34	7	28	13	15	7	19
	169	100	122 (72%)	47 (28%)	104 (61%)	65 (39%)	61 (36%)	29 (17%)	79 (47%)

*See lists of long-term patients, Section V, page 150.

It is evident that on this one day the patients hospitalized from four to eight months constituted well over a third of the long term cases, those from one to five years and from three to four months constituting each about one quarter. The high percentage of adults reflects the scarcity of facilities for the adult chronic patient; and the percentages of full pay, part pay and free cases, the economic groups for which institutional care is sought. As the per capita cost of care in a hospital for the acutely sick is more than double that of an institution for chronics, it is apparent that the free care furnished the 108 part-pay and free patients is an expensive form of charity.

It is not presumed that all the 169 patients are chronically sick, as the mere fact that patients are hospitalized for a three months' period or longer does not necessarily mean that they are not properly hospital cases. But even a brief study of the diagnoses of these patients suggests the probability that at least 90 per cent do not belong in general hospitals maintained for the acutely sick.

The problem of the chronically sick could properly be made a subject of special study by a committee of the proposed Hospital Council. The facts made available through the national study previously mentioned

would furnish valuable aid in formulating standards and developing a program.

The sympathy and understanding with which so many free patients have been maintained without charge or at exceedingly low rates for so many years, justifies the opinion that the individual hospitals have a considerable knowledge of the patient groups for which provision should be made, invaluable in the study of the problem.

Increased social service facilities for all hospitals, and particularly at the San Francisco Hospital, would be of material assistance in dealing with the type of problem presented in the chronic patient. The establishment of a visiting nurse service would make it possible to care for a certain number of chronic patients in their homes. This has been the experience of many other localities. For example, the Victorian Order of Nurses in Montreal maintains two visiting nurses, especially selected because of their personal interest and fitness, who care only for cancer patients in their homes.

Although the number of long-term patients in the hospitals furnish some index of the chronically sick for whom special institutional provision should be made, any well considered plan for this patient group would naturally include consideration of the service which would be available through,

(a) Increased social service.

(b) The establishment of a visiting nurse service.

(c) Increased facilities for hospital care at the Hospital of the Relief Home.

SECTION IV

Recommendations

Chapter 1

GENERAL POLICIES

While it is recognized that the elementary reason for the association of the privately supported agencies operating for the prevention and relief of dependency and disease, as members of the Community Chest, was to reduce duplication of appeals for funds and to secure adequate proportionate support for all such community services as seemed to be indispensable, the organization of functional committees and the undertaking of this survey express a determination on the part of the officers of the Chest to direct inquiry into the social causes and results of preventable sickness, as well as to relieve manifest distress, to crystallize public opinion in the field of health promotion, and to prepare plans for better services capable of using all the resources of the community for the care of sickness and the protection of health.

"The holding of public confidence through educational work all the year round, is the rock upon which the success of a federation must be built. Success or failure in raising the combined budget is not a cause, but an effect of public understanding."

"How can the Community Chest vitalize community social work by securing active, continuing personal participation in the work of individual agencies? Federated financing, by freeing the agency executive of the burden of money raising, gives him an unexampled opportunity for enlisting the interest of thoughtful people in the work of his particular agency, without regard to the size of their monetary contribution." (Survey—June 15, 1923.)

While it is obvious that there should be justification for the expense of a survey in the specific recommendations dealing with appropriations requested by individual institutions, it has been understood that policies, plans and programs affecting existing public tax-supported agencies, or dealing with proposed new private agencies should be considered whether or not they affect the financial obligations of the Chest.

The scheme of organization of the Community Chest of San Francisco is such that while proper control of finances is vested in a group chiefly experienced in business and commerce, excellent protection of the interests of the professional groups responsible for the technical services to the community is provided through representation from the important committees such as that on Hospitals and Health Agencies.

It is believed to be the wise policy, for the present at least, for the Community Chest to use its position to sponsor or disapprove of fund

raising for endowment or building purposes, but not to participate in efforts to add to the capital account of any of the agencies or institutions for the current expenses of which it now makes appropriations.

If the Community Chest makes an appropriation to a hospital or dispensary on the basis of the amount of service to the sick for which the hospital is not paid by patients, it is obvious that such a hospital must agree to accept patients for care even when these are not able to pay, as long as there are services available appropriate to the needs of the applicant.

Of the twenty cities* of over 100,000 population in the United States and Canada where federated fund raising and central control of distribution of voluntary contributions were in effect as of June, 1923, appropriations were made to some or all of the privately supported hospitals of the community in all but three instances (Denver, Minneapolis and Portland, Oregon), although the sums allotted to hospitals in many instances were often only to meet the expense of social service work for the patients.

In a bulletin (No. 12) upon the Non-Financial Activities of Federations and Chests, issued in June, 1923, by the National Information Bureau, a great majority of the sixty-six communities reported upon included in the functions of the Chest or Federation very important non-financial activities.

Among the benefits which Community Chests have brought to a number of cities are: study of the community as a whole to permit of a reasoned diagnosis of social, economic and health problems; central collection of facts as to the service of all similar agencies; standardization of practice in reporting upon the operation of hospitals, based upon uniform bookkeeping methods.

To accomplish these results in San Francisco it will be found necessary to establish a Hospital Council upon which there will be represented the managing board and the administration of each hospital whether or not the hospital receives funds from the Chest. A central purchasing bureau would probably be the first activity of such a council.

It will probably be found as progress is made in the co-ordination of agencies dealing primarily with health, as distinct from sickness problems, and in the formation of a hospital council, that the Committee on Hospitals and Health Agencies of the Council of Social Agencies will be concerned almost wholly with the health work and will need some one trained in collecting and interpreting the facts upon which policies in health administration and education are based, to act as a permanent secretary.

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*Cincinnati, Grand Rapids, Montreal, Canada; Portland, Oregon; St. Louis, The Oranges, N. J.; San Francisco, Toledo, Ontario; Minneapolis, Philadelphia, Cleveland, Kansas City, Oakland, Rochester, St. Paul, Dayton, Milwaukee, Detroit, Seattle, Denver.

Chapter 2

DEALING WITH THE APPROPRIATION OF FUNDS BY THE COMMUNITY CHEST TO THE PRIVATELY SUPPORTED HOSPITALS AND HEALTH AGENCIES

It is understood that appropriations for capital account are not considered to come within the scope of the Community Chest at present. Therefore, under this section of the recommendations only such items will be considered as are properly included under current expenses, or maintenance and operation.

Before offering suggestions as to appropriation by the Community Chest to hospitals which are now receiving or have applied for funds, the principles upon which allowances from a common purse should be made to agencies giving care to the sick should be agreed upon.

Inasmuch as the interest of the contributor to a community chest is theoretically not in institutions but in services to his fellow citizens who may be sick or indigent, we should measure the right of a hospital, dispensary or other agency for care of the sick or protection of health to participate in the fund collected, by the quantity and quality of services which the particular institution or agency can show from its books have been rendered, which have not been paid for by the patients or through other earnings, or endowments.

Two other bases are now in general use to determine the amounts to be appropriated to hospitals, that of the deficit in annual operations, and that of the sum of voluntary contributions from the public in recent years, the use of either of which may be justified as a temporary expedient pending the collection of comparable facts as to the amount, quality and cost of service given, but neither of which should be adopted as a continuing policy by a community chest or welfare federation.

It will presumably always be a matter of pride and rivalry among hospitals not only to give as high a quality of medical service as the patient needs but to provide this at as low a cost as good administration permits.

Since no fair basis of measurement of quantity, quality or cost of hospital or dispensary care can be arrived at among the hospitals of San Francisco until modern accounting methods and departmental records of service and unit costs are adopted, approximately on a uniform basis by all the medical service institutions, and until the services are so reported that the number of days of hospital care, or the number of visits of patients to dispensaries can be classified according to the main medical groups, such as medical, surgical, obstetrical and children, and according to their financial relation to the hospital, i. e., free, part-pay or full-pay patients, and the cost of services can be reported upon by substantially these same groups where practicable, no institution can make its right to

a particular sum from the Community Chest clear to the Trustees of the Chest.

It is to be clearly understood that in calculating the cost of hospital and dispensary care there should be included the expense of laboratory diagnostic procedures and special therapeutic treatments, as disclosed by an accounting for the operation of these services, not as based upon arbitrary schedules of prices charged, comparable to those of commercial organizations operating for profit.

It is obvious that there will be considerable variation in the cost of essentially similar services given at different hospitals, according to the comfort, space, character of personnel, housekeeping standards, etc., and it may prove necessary for the Chest to establish a maximum per capita cost of care for bed and dispensary patients, beyond which the cost of treatment of the sick will not be met, except where there is some particular or special treatment unobtainable elsewhere, and essential to the life and health of individual patients.

It is recommended that:

1. *Basis for 1924 Appropriations*—Appropriations for 1924 to hospitals and dispensaries be continued on the same basis as in 1923, although this is recognized as an unsuitable permanent or continuing financial policy. The principle upon which appropriations should be made, namely, for such amounts as can be shown by a hospital or dispensary to have been spent for the care of the sick which patients have not met in whole or in part by their own payments for care, cannot be adopted until next year, because it will not be possible in a shorter period to institute in the hospitals and dispensaries such a system of cost accounting and bookkeeping as will permit monthly reports to the Community Chest of the services rendered to free, part-pay and full-pay patients, and their cost.

As soon as practicable after such a system is put into operation in any hospital or dispensary the Community Chest should use the monthly reports of hospital operation and the costs of free services as the basis of annual allotment of funds to these institutions, having in mind at the same time the importance of providing for improvement in quality and completeness of service as well as the propriety of meeting the cost to which an institution has been put in caring for the sick of the community who could not pay all or any of the expenses of their treatment.

2. *Franklin and University of California Hospitals*—That special reconsideration be given to the matter of appropriations to the Franklin Hospital and to the Women's Auxiliary of the Out-Patient Department of the University of California Hospital:

(a) *Franklin Hospital*—In the case of the Franklin Hospital (which received an appropriation of $15,000 in 1923), a subsidiary of the German General Benevolent Society, organized for sickness insurance and other purposes on a commercial basis, the hospital appears to have closed its year's operations in 1922 with a profit of $545, which was applied to a reduction of the $34,195 deficit shown on the books of the benevolent

association. Furthermore there appear to be carried on the pay roll of the hospital the salaries of four physicians whose functions are solely to serve the members of the Benevolent Society. In estimating the cost of free service provided by this hospital to the sick of the community these salaries should not be included.

(b) *University of California Hospital*—As to the Women's Auxiliary of the Out-Patient Department of the University of California Hospital it is suggested that it is an unwise policy for the Community Chest to make any appropriation for services to the sick which are supplied by a hospital supported by city or state taxes. Social service differs in no essential from various other hospital or dispensary services of a professional nature. The fact that the Regents of the University have not seen fit to provide for all the medical social service which is found necessary at this hospital, while they have supplied funds adequate for dietetic, anesthetic, nursing and other services of a professional character, is a matter of much public interest, but it is not conceived to be the duty or proper function of private agencies, using funds collected through voluntary contributions, to select one particular essential function of a state tax-supported hospital and relieve the tax levy of this burden.

Such part of the funds which have been spent by the Women's Auxiliary of this hospital, as have been used for material relief of the indigent sick, should be provided through existing general relief agencies in the city.

It is quite possible that the Community Chest may feel that the medical social service provided in the interest of the patients of the University of California Hospital is too important to allow it to lapse until the State provides for it. If so, is it not obviously the duty of the Chest to provide for similar service at the San Francisco Hospital, where the city has not yet installed it?

With regard to appropriations requested by the University of California Hospital to meet the cost of care of free or part-pay patients, resident in San Francisco, it is considered that subsidizing a tax-supported public hospital through charitable funds would be a fundamentally wrong principle to establish.

3. *Lane and Stanford University Hospital*—With regard to the requests of the Stanford Clinics Auxiliary and the San Francisco Maternity, and the Lane and Stanford University Hospital it is recommended that these be granted in 1924 as in 1923, but it is suggested that in the future no separate appropriations for hospital or dispensary services for free and part pay patients be considered. All hospital departments should be under the direct administrative supervision and control of the superintendent through whom all requests for funds should go to the managing board of the hospital, the latter to approve appeals for appropriation from the Community Chest. The facts that Lane and Stanford University Hospital received no money from city or State taxes, that it is the hospital of an important teaching institution, and that, coupled with high-grade professional and nursing services, there has been provided a medical social

service department of excellent quality, all seem to justify particularly favorable consideration of the request for such funds as will permit this hospital to offer more beds for the care of free and part-pay patients.

4. *Osteopathic Clinic*—It is recommended that no appropriation be made to the Osteopathic Clinic for the reason that the services for the sick are of a quality too low for the Chest to sponsor. It is doubtful if anything approximating adequate or responsible diagnosis and treatment of disease, as these are understood and practiced in the other medical institutions assisted by the Chest, is to be had at the Osteopathic Clinic.

5. *French Hospital*—It is recommended that no funds be granted to the French Hospital of the Societe Francaise de Bienfaisance Mutuelle. It appears from the report of the Society that in 1922 of the 46,766 days of hospital care provided, but 103 days of care were given to patients who paid no part of the cost of their hospital services.

It appears that in 1922 the fees of beneficiaries of the Society, a sickness insurance association, organized on a commercial basis, which operates the Hospital, together with fees of other pay patients, met all operating expenses and left a balance of profit for the year of $14,092.

6. *Mary's Help and St. Mary's Hospitals*—A situation exists in Mary's Help and St. Mary's Hospitals peculiar to hospitals managed by Catholic Sisterhoods where many of the professional, nursing, administrative and office positions are filled by Sisters, for whose salaries no sum is set aside in the hospital budget equivalent to the amount which would have to be paid at prevailing rates for these services.

The Community Chest would be justified in making appropriations for the present to these two Catholic hospitals on the same basis as in the case of other privately supported hospitals, but several situations brought about in the financial status of the Sisters' hospitals by the gift of their services require consideration before establishing a definite policy for the future.

It appears that at St. Mary's Hospital, in 1922, income exceeded expenditures to the extent of $31,207, which is $7807 more than the hospital would have had to pay for Sister services if the usual rates for equivalent positions had been paid here as in the case of other hospitals in San Francisco. The profit shown on the books for 1922—$31,207—was added to the capital account of the hospital, and any appropriation of the Community Chest to this institution under these conditions would to all intents and purposes constitute a contribution to the hospital's building fund, an objective alien to the purposes of the Community Chest at present.

Similar facts cannot be presented for Mary's Help Hospital, as this institution did not furnish a complete financial statement. However, it is estimated that the Sisters' services for hospital purposes represent a sum of $14,700 a year, at present rates for equivalent positions.

When the cost of hospital or dispensary care of free and part-pay patients at either of these two hospitals is presented, as suggested in the

introductory remarks of this section, there should be shown as a book-keeping item of hospital expense a sum equivalent to the estimated value of such Sisters' services as are devoted to hospital work, and the per capita cost of care per day or the cost of a dispensary visit should be based on a total of expenses which includes this item.

7. *Proposed Hospital Council*—It is recommended that for 1924 the Community Chest provide the funds necessary to meet the cost of a Hospital Council, the functions of which would be ultimately as suggested in Section III, but for the present should consist, so far as paid services are concerned, of a central record office and purchasing bureau supplied with a modest revolving fund to permit of the taking advantage of cash discounts, etc. It is believed that an initial annual expenditure of not over $15,000 would show savings to a considerably greater amount in hospital expenditures and at the same time provide the opportunity and occasion for a continued and current study of all hospital problems.

8. *Secretary to Proposed Health Council*—It is recommended that the position of Secretary of the proposed Health Council be created in the offices of the Community Chest or Council of Social Agencies, such a position to be held preferably by a physician qualified in public health work, possibly on part time, the functions of this office to be as described in Section II, but at least to include those of executive officer of the proposed Health Council under which he would initiate and share in carrying through more detailed studies of the health services of San Francisco than was found possible during the Survey herewith reported.

9. *Assistant to Division of Child Hygiene of the Department of Public Health*—It is recommended that until the city provides the funds, the Community Chest appropriate up to $5000 towards the salary of a full-time physician to assist the Health Officer in developing a complete program of Child Hygiene as outlined in Section II.

It is not considered a proper policy for a city employe to be paid by a private organization, nor that a private agency should decide upon and pay salaries to those in public office or serving public functions, which are out of proportion to the salaries paid on the city budget. However, it ought to be possible to make available to the Health Officer and for public service in that field an assistant whose salary the city would soon meet; such a person, for instance, to supplement rather than replace the present part-time physician, head of the Bureau of Child Hygiene of the Health Department, and to be responsible to him. A precedent for such private subsidizing of city health personnel has occurred in the field of tuberculosis work, where salaries of Department of Public Health nurses were for a time met by the San Francisco Tuberculosis Association and from private contributions.

10. *Hospitals Establishing Social Service Departments*—It is recommended that the Community Chest encourage each of the hospitals and independent dispensaries to which it may allot funds for general maintenance and support, to establish medical social service under its own independent direction, and that, to secure the early establishment of such an essential

professional service in connection with the medical and nursing services as they are now usually organized, the Community Chest offer to meet the expense of at least one trained medical social worker in each of the assisted institutions.

It may be found impracticable for the San Francisco Hospital to add an adequate medical social service to its existing hospital facilities, as promptly as is recognized to be desirable by the Board of Health, the Health Officer and the Superintendent of the Hospital. Until such time as this service, of particular value to the sick poor of the city, for 92 per cent of whom the San Francisco Hospital provides bed care, is established and maintained out of the tax levy, it is probable that through joint action of the relief agencies much could be done to remedy the incompleteness of hospital care, as revealed in the study of recently discharged patients. For such additional social service if provided by competent medical social workers, the Community Chest might be asked to contribute further to the social and relief agencies.

11. *Establishment of District or Visiting Nurse Association*—It is recommended that a sufficient sum be set aside in 1924 to meet the expense of organizing and establishing a District or Visiting Nurse Association under the auspices of the Community Chest or of the Council of Social and Health Agencies.

Educational services and health protective as well as sickness and maternity bedside care in the homes, under the direction of the private physicians or of physicians of hospitals and dispensaries, are nowadays recognized as so fundamental a part of a sickness and health service in any community that the establishment of such is strongly urged. In a city such as San Francisco, where there are only 1200 families among the whole population found to require material relief, it is altogether likely that a visiting nurse service for free, part-pay and full-pay patients in their homes, such as is contemplated, would soon become at least 60 per cent self-supporting. It is of primary importance that the directing body or managing board of such an organization be formed of men and women, among whom there should be representative physicians, nurses and men and women with a knowledge of social and relief work, but the actual administration of the services should be left to a Director of Nurses, equipped by training and experience in public health nursing, and wholly untrammeled in the sphere of her professional work.

It is particularly fortunate that just at this time there has been completed the first nation-wide study of the organization, costs, and services of visiting nurse associations by a committee of the National Organization for Public Health Nursing. The report of this Committee's work will be available in preliminary form within a month for the use of the Community Chest and it is recommended that action in the matter of organizing a Visiting Nurse Association await careful consideration of this text.

12. *Convalescent Homes and Homes for Chronic Invalids*—It is recommended that the Community Chest authorize and use its influence to endorse and encourage the raising of funds for the erection of Convalescent

Homes and Homes for Chronic Invalids where those able to pay all or part of the cost of their care should be provided for, when they are no longer in need of the services and equipment of a hospital primarily designed for the care of acute and relatively brief periods of illness. This is a matter which concerns intimately the problems of hospital operation, for at present an excessive expense is being met by the hospitals for the care of many convalescent and chronic invalids who could be as well or better provided for at half the daily cost per capita in Homes constructed and operated to meet their particular needs. The need of materially increasing the hospital facilities of San Francisco can be postponed for many years if adequate provision is made for chronic and convalescent patients who now use hospital beds to the disadvantage of themselves and to the excessive expense of the hospitals.

In addition to the provisions planned for or under construction under the auspices of the Board of Health at the Relief Home there are now needed for the patients improperly provided for in the hospitals of San Francisco 100 beds for chronic invalids. There are 265 beds needed for convalescent patients. To meet these needs there are at present only thirty-nine beds for chronic invalids, and eight more under construction for cancer patients, and sixty-nine beds for convalescents, with thirty more under construction.

Chapter 3

DEALING WITH PROGRAMS IN THE FIELD OF PUBLIC HEALTH FOR THE PROMOTION OF WHICH THE COMMUNITY CHEST MAY BE EXPECTED TO LEND ITS DIRECTING INFLUENCE

1. *Health Education*—First in order of importance in the field of health promotion, sickness prevention, and the postponement of death is education of the public in the principles of right living and in the means of self-protection.

The two logical and appropriate agencies for carrying on education in health are the schools and the Board of Health. There is needed a policy, a plan and the practice of education of children in each grade, according to their capacities, in the simple biological truths upon which health, its establishment and maintenance depend.

It is not additional teachers or new or more equipment that is needed in the schools but such rearrangement of subjects, with such alteration of emphasis, example and proportion in the school curriculum as will permit the teaching of the facts of life in every department. Teaching of hygiene, or physical training or kindred subjects as additions to a crowded curriculum will never accomplish our purpose, which is to have health, and knowledge of it permeate the teaching of every topic of the school course, and the daily practice of teachers and children.

A Board of Health which is allowed no appropriation by the city to permit the Health Officer to carry out any educational activities except through the occasional opportunity of lectures to groups of adults, cannot perform one of the most important functions for which it is created. A Health Officer who cannot spend the price of a postage stamp to send out bulletins on the city's health status, or even assemble and print a record of the annual death rate and preventable causes of death, is powerless to use his position of influence and high prestige in the community to spread the knowledge of health liabilities and assets. According to the conservative estimate of reasonable expenditures for health purposes as expressed by the report of the Committee on Municipal Health Department Practice of the American Public Health Association, the appropriation for health education by the Board of Health should, in San Francisco, amount to $20,520.

However much the public agencies for education have to spend, or however successful they may be in application of their appropriations for this purpose, there will always continue to be a need for organized educational effort by all the private agencies operating in the realm of preventive medicine.

It is recommended that the Community Chest arrange for periodic conferences on the subject of health education for the purpose of committing public and private agencies to a coherent and progressive program and to attract the attention of the public to this important resource for self-protection.

It is recommended further that a standing committee of the Council of Social and Health Agencies or of the proposed Health Council of San Francisco be called together to undertake continuous agitation for and organization of education of the public in health through all possible channels. An uninformed, skeptical, superstitious public is more dangerous than a polluted water supply or unpasteurized milk.

2. *Child Hygiene*—Only second in interest and probably in importance to health education is the protection of child life, from the period of prenatal existence to the age of independent support on graduation from school.

The program for child health is nowadays so well understood and the desirable elements are so generally accepted that little of argument or description is required. The following are the important features of the existing services which need reinforcement or extension:

(a) Prenatal supervision of expectant mothers should be extended, partly through five additional baby centers which might well be established by the Department of Public Health, and partly through the hospitals which offer maternity care. Only when a routine Wassermann test is taken and supervision of each expectant mother, following a medical examination, is provided for in the last five months of pregnancy, do we find that the maximum reduction in maternal and neonatal mortality occurs.

(b) There is apparently some duplication in the work of the Haight

Street Center so far as prenatal supervision is concerned, which might be eliminated by referring such patients to one of the six prenatal clinics operated in connection with large general hospitals.

(c) Supervision of the 105 midwives should occupy the entire time of one nurse of the Department of Public Health.

(d) Nursing follow-up of mothers recently discharged from hospital care is one of the many needs which cannot be met until a visiting nurse service is provided which will reach all parts of the city and be available for all kinds of patients.

(e) As many as four additional nurses should be added to the present force of the Department of Public Health to permit of supervision of more babies at Well Baby stations.

(f) Detection of nutritional defects of children and institution of appropriate remedial measures will never be adequate until in each instance the diagnosis and treatment is determined by medical examination of the child who shows a weight 10 per cent or more below the usual for the height and age of the child.

(g) The same special diagnostic skill should be provided for such children of the preschool or school ages as is recognized as necessary in the cases of cardiopathic or pretuberculous children.

(h) It is recommended that additional provision be made for the special consultation clinics for school children organized at appropriate times of the day and week, in connection with the pediatric clinics of the hospitals of the two medical schools, to which more difficult, doubtful or problem cases may be referred by the medical inspectors of the Department of Public Health for opinion. The medical examination of children in the schools does not permit of such completeness or accuracy as is desirable. These special clinics should provide for the child showing mental and behavior disturbances as well as for those with nutritional, cardiac or other diseases and disorders.

(i) There are needed now to provide adequately for the medical and nursing supervision of the health of school children not less than eight additional nurses, three part-time physicians, a full-time dental hygienist and a traveling dental clinic.

(j) There is needed in each of the eighty-five schools of the city provision for at least two classes of thirty children each, operated upon the open-air basis. This would accommodate the 5100 children who are known to be suffering from malnutrition, anemia, pretuberculous conditions, etc., who can best be handled in open-air classes.

(k) The follow-up of the children who leave day school for employment, with working certificates issued by the Department of Public Health, should be undertaken through the night schools which they are required to attend.

An addition of approximately $30,000 to the present budget of the Department of Public Health would meet the need of personnel in the

field of child hygiene, this to include the salary of the full-time physician to lead in organizing a community program in this field.

3. *Tuberculosis*—The tuberculosis situation in San Francisco has recently been so carefully studied by both local and national organizations that little can be added to the program already approved by competent authority.

As long as the reporting of tuberculosis by physicians is incomplete, while enough hospital beds are not provided for those in the active open stages of the disease, and while patients recently discharged are permitted or forced by circumstances to return to work, of a kind and amount quite certain to determine a return of the active stage of the disease, there will be need for increasing and persistent activity on the part of public and private agencies.

Specifically there are needed to accomplish actual control of tuberculosis in San Francisco:

(a) Education of physicians in the necessity of early reporting of cases of the disease, if necessary by pressure through the authority of the Board of Health.

(b) Provision of about 250 more beds for patients in the communicable stage of the disease: 50 for children in wards on the roof of the San Francisco Hospital; 80 for chronic cases of the disease in adults who need custodial rather than special medical care, in units to be provided at the Relief Home; 120 for early favorable cases, adults and children, who need sanatorium care at the proposed new city institution at Redwood City.

(c) Home supervision and follow-up after discharge from sanatorium or hospital care in an arrested stage of the disease, coupled with economic rehabilitation, or "industrial convalescence" to be provided by supervised occupation, on a part or whole-time basis in a specially administered work shop, and ultimately placement in such work as will offer the best chance of avoiding relapse and permit of self-support.

Public health education as urged above in this chapter and the organization of a visiting nurse service throughout the city as proposed in Chapter 2 of this section, together with a fuller development of the program for child hygiene, should be considered as important elements in a satisfactory plan for better control of tuberculosis.

4. *Mental Hygiene*—While the requirements of those burdened with disabilities of the mind and inadequacies of personality have been largely ignored in the past in the plans for care of the sick and in the field of preventive medicine, the physicians and others in San Francisco who constitute an informed group, technically proficient and eager to see adequate provision, are in entire agreement as to a program which will correct old abuses and failures of service.

(a) There should be provided at the San Francisco Hospital fifty beds for mental disease, for the present in the existing buildings, but

later preferably in a separate unit devoted especially by appropriateness of equipment and personnel to the care of acute committable cases.

(b) At the University of California Hospital forty beds are needed, fifteen for observation and diagnosis, twenty-five for treatment of mental disease and all to be used in the teaching of medical students and physicians.

(c) At the Lane and Stanford University Hospital there should be provided thirty-five beds, ten for diagnosis and twenty-five for treatment.

(d) Out-patient services for mental disease, including psychiatric social work, psychological analysis, and sufficient stenographic work to permit of competent records, should be developed at the San Francisco and Mount Zion Hospitals and at the hospitals of the two medical schools.

(e) There should be added to the present scope of medical inspection of school children, psychological survey of all, and psychiatric study of such children as appear to be abnormal in their mentality or to be suffering from disturbances of personality, or in the field of their emotional life.

(f) Provision for emergency commitment of persons with mental disease, and for parole to the supervision of psychiatric clinics or hospitals would save much expense of institutional custodial care and in many ways contribute to the promptness and humanity of the protection afforded these patients.

(g) A clinic devoted to the study and demonstration of the relationship between the delinquency of children and adults and mental diseases, would serve the schools, the courts, and the social agencies, and might be expected to disclose the fact that two-thirds of the problems of dependency and crime have their origin in errors of mentality and behavior as has been shown in other large cities of the country.

5. *Venereal Diseases*—What is known as "The American Plan" for venereal disease control is so well known that any detailed recommendations based upon it would appear superfluous. Furthermore it is now fully recognized that only by a plan which includes educational, recreational, social, religious and legal as well as medical and public health measures will any marked or permanent impression be made on those relationships which largely determine the extent of infection of a community with syphilis and gonorrhea.

(a) It is recommended that more effective measures, through official action of the County Medical Society, through appeals to the conscience and sense of public responsibility of the individual physician, and through the pressure of the authority of the Board of Health, be taken to obtain a more general reporting of venereal diseases as required by State law and local ordinance.

(b) More clinic facilities are needed to provide for early accurate diagnosis and thorough treatment of those who do not require hospital

care, and to supply the necessary follow-up which will insure the patients' return for treatment until their infections are cured.

(c) The present practice of the privately controlled hospitals to exclude such patients from their wards and rooms as require hospital care for active syphilis and gonorrhea in the communicable stages of these diseases should be abandoned, and patients, whether on the free, part-pay or full-pay basis, should be provided for, if necessary in wards and rooms set apart for venereal diseases.

(d) A committee of the proposed Health Council should be organized to consider all phases of the problem of venereal diseases, and to plan for such measures as will reduce exposure to and infection by syphilis and gonorrhea.

6. *Heart Diseases*—The entry of heart diseases into the class of preventable disorders is relatively recent, but enough is known of the primary causes, and of the reasons for development of increasing disability and premature death from heart affections to justify the preparation of a program for prevention and relief. While San Francisco provides some of the elements for such a program, there is still inadequate provision for diagnosis and medical supervision of the cardiopathic child of school age, there is no channel for public education in the matter of prevention of heart diseases, there is no place where either convalescent or chronic cardiac patients can be cared for outside of general hospitals, there is no trade school training for children handicapped by a disability of the heart, and requiring a special vocational guidance, and there is no placement bureau for wage earners where patients from hospitals and clinics can be provided with employment suited to their disabilities and yet permitting self-support.

7. *Cancer*—The peculiarly high cancer mortality in San Francisco, even if it proves to be due chiefly to the relatively high percentage of persons over 40 years of age among the population, attracts special attention to the inadequacies of service for its prevention and treatment.

(a) Much more educational work such as has already been initiated by leading surgeons of the city is needed, to inform the people of some of the easily preventable causes of cancer, of the resources for early and accurate diagnosis, and of the necessity of prompt action if a positive diagnosis is established.

(b) Beds, at least in the San Francisco Hospital and in several of the other general hospitals, should be kept available for care of cancer patients until such time as other provision is made for inoperable, incurable invalids from this disease.

(c) Home nursing, which could be provided only through a visiting nurse service such as has been already suggested, is urgently needed for the many cancer patients who cannot find accommodation away from home, in hospital, or home for incurables under such conditions of privacy and care as will be acceptable to those who expect to pay all or part of the expenses of such service.

(d) It is recommended that the Board of Health add cancer to the list of reportable diseases and obtain the co-operation of the medical profession in reporting their cancer diagnoses.

8. *Health Examinations*—It is recommended that an annual health examination be arranged for in the case of each permanent employe of the public or private hospital or health agencies considered in this report. So far as possible this should be provided at the expense of the organization, institution or agency and should meet the standards proposed by the American Medical Association for such periodic examinations.

SECTION V

Forms, Lists, etc.

FORM NO. 1

(Form Letter Sent to Members of the San Francisco County Medical Society)

COUNCIL OF SOCIAL AND HEALTH AGENCIES
OF SAN FRANCISCO

Room 516, Sharon Building; Telephone Douglas 9160

President, Dr. Ray Lyman Wilbur — Executive Secretary, Mabel Weed
Vice-Presidents, Rev. Michael R. Power, Miss Alice Griffith

19 June, 1923.

.....

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Dear Doctor:

This is an appeal for information which can be obtained only from physicians. At the request of the Council of Social and Health Agencies of the Community Chest of San Francisco, I am studying the existing hospital, clinic, and health services of the city, with a view to determining their adequacy for the protection of health, and for care of the sick.

Can you spare the brief time and attention necessary to answer the following questions? Answers to this letter will be held confidential, and only tabulations of the facts furnished will be made public:

1. Are you a member of any hospital or dispensary staff, and in what capacity?

2. Are you connected in an advisory or professional capacity with any official or volunteer health agency, and in what capacity?

3. Do you have difficulty in obtaining care or service of the kinds suggested below for free, part-pay or full-pay patients?

	Medical.....	Surgical.....	Obstetrical and Gynecological..	Pediatric.....	Ear, Nose and Throat.....	Eye.....	Orthopedic.....	Venereal and Genito-Urinary.	Mental and Neurological...	Dental.....
Hospital Care.....										
Dispensary Treatment.										
Home Nursing.....										
Convalescent Care.....										

4. Is it your opinion that more hospital beds or increased dispensary services are needed in this city?

5. Do you believe that adequate precautions are taken to prevent the abuse by patients of free medical and hospital services?

6. Please mention any inadequacies of service with which you are familiar among official or volunteer agencies dealing with prevention of disease, or treatment of the sick.

If possible, please let me have your reply, in the enclosed envelope, not later than Friday, June 22.

Yours very truly,

(Signed) HAVEN EMERSON, M. D.,
Director of Hospital and Health Survey.

Questionnaire filled out and returned by

....., M. D.

FORM NO. 2

(Form Letter Sent to Social and Health Agencies)

COUNCIL OF SOCIAL AND HEALTH AGENCIES
OF SAN FRANCISCO

Room 516, Sharon Building; Telephone Douglas 9160

President, Dr. Ray Lyman Wilbur — Executive Secretary, Mabel Weed
Vice-Presidents, Rev. Michael R. Power, Miss Alice Griffith

20 June, 1923.

My dear.....

May I have, as a confidential communication from you, and not to be quoted, your answer to the following questions:

(a) From your experience and observation what, if any, of the following facilities for free, part-pay or full-pay patients are lacking in San Francisco?
Hospital bed care.....
Dispensary or clinic service.....
Home or Visiting Nurse Service.....
Convalescent bed care.....
Institutional care for chronic patients.....
Medical Social Service.....

(b) Please indicate which of the following classes of patients lack medical or social services necessary for their complete recovery:

1. Medical .....
2. Surgical .....
3. Obstetrical and Gynecological.....
4. Children .....
5. Ear, Nose and Throat.....
6. Eye .....
7. Orthopedic .....
8. Venereal and Genito-Urinary.....
9. Mental and Neurological.....
10. Dental .....

(c) What services, if any, within or outside of your own institution or agency, do you believe to be of special importance to render more effective and complete the work your institution is responsible for?

Please do me the great courtesy of returning your answers to these questions, in the enclosed envelope, to me not later than Friday, June 22.

Thanking you for your assistance in this matter, I am,

Very truly yours,

(Signed) HAVEN EMERSON, M. D.,
Director of Hospital and Health Survey.

EXHIBIT A

(Monthly Report Form Used by Hospitals Belonging to the Cleveland Hospital Council for Reporting Hospital Statistics to the Welfare Federation of Cleveland)

STATISTICAL REPORT
Of the
.....HOSPITAL
To the
WELFARE FEDERATION OF CLEVELAND
For the
Month of ....., 192...

Section I—Hospital

1.	Patients in Hospital at first of month.....		.....
2.	Admissions:		
	(a) Full pay	.....	
	(b) Part Pay	.....	
	(c) Free	.....	
	(d) Births	.....	
	(e) Total Admissions		.....
3.	Total Patients in Hospital during month.....		.....
4.	Deaths within 48 hours.....	.....	
5.	Institutional Deaths	.....	
6.	Discharges	.....	
7.	Total Deaths and Discharges.....		.....
8.	Patients remaining at end of month.....		.....
9.	Admissions:		
	(a) Men	.....	
	(b) Women	.....	
	(c) Children 14 years and under.....	.....	
	(d) Residents of Greater Cleveland.....	.....	
	(e) Residents elsewhere	.....	.....
10.	Patient Days' Treatment (Under the classifications given, include registered cases remaining less than 24 hours):		
	(a) Medical	.....	
	(b) Surgical	.....	
	(c) Obstetrical	.....	
	(d) Full Pay	.....	
	(e) Part Pay	.....	
	(f) Free	.....	
	(g) Infants	.....	
	(h) Total		.....
11.	Operations Performed:		
	(a) Major	.....	
	(b) Minor	.....	
	(c) Total		.....

12. Laboratory Examinations ....
13. X-ray Treatments, Pictures, etc..... .....
14. Applicants Rejected (Causes for rejection):
    (a) Lack of Beds..... .....
    (b) Inability to pay..... .....
    (c) Cases Unsuitable for Hospital Care..... .....
    (d) Disease condition not one which Hospital is fitted to treat ....
    (e) Other causes (specify if possible)..... .....
    (f) Unknown or no record..... .....
    (g) Total Rejections ....

Section II—Dispensary

1. New Patients:
    (a) Men ....
    (b) Women ....
    (c) Children 14 years and under..... .....
    (d) Total New Patients..... .....
2. Revisits ....
3. Total Visits ....
4. Give any other facts or figures that may be available.
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Section III—Social Service Work

1. Ward Visits ....
2. Home Visits ....
3. Other Visits ....
4. Total Visits ....
5. Give any other facts or figures that are available.
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Section IV—Additional Items of Service

(Include items not reducible to statistics—i. e., clinics, educational work, co-operation with other agencies, etc. Also publicity material. Use extra pages if necessary.)

Section V—Personnel

(Report only semi-annually, as of June 30 and December 31)

1. On Visiting Staff..... .....
2. On Resident Medical Staff..... .....
3. Graduate Nurses ....
4. Student Nurses ....
5. Day Nurses ....
6. Night Nurses ....
7. Other Employes ....
8. Total Employes ....
9. Number of Employes and Staff who take meals at Hospital ....

Notes

1. Pay patients are those for whom at least the cost of their care is paid.
2. Part-pay patients are those for whom only part of the cost of their care is paid.
3. Free patients are those for whose care nothing is paid. (Uncollectable bills should not be included under this head.)
4. No class of patients or important work performed by the Hospital should be omitted from this report.
5. Along with these reports, please send any publicity literature, such as pamphlets, programs, printed reports, etc., that the Hospital may issue.

FORM NO. 3

(Form Used in San Francisco Survey for Collecting Information at Homes of Recently Discharged Patients to Determine Convalescent Needs)

Hospital .....
Hospital No.....Private Patient?.....
Name .....
Address .....
Full Pay.....Free.....Sex.....Age.....
Part Pay (state rate paid) $.....
Dates:
Admitted..... ..... Discharged.....
Where Referred on Discharge:
Hospital's Clinic.....Other Clinic.....
Private Doctor.....S. S. Dept.....
Social Agency.....Other .....
Diagnosis .....
Condition on Discharge.....

Date of Home Visit:

Patient's Needs	Provided		Not Provided	
	By Hospital	Suggested by Hospital and Otherwise Provided	Suggested by Hospital	Not Suggested
Hospital Care	.....	.....	.....	.....
Clinic Care	.....	.....	.....	.....
Home Nursing Care	.....	.....	.....	.....
Convalescent Institutional Care.....	.....	.....	.....	.....
Chronic Institutional Care.....	.....	.....	.....	.....
Instruction	.....	.....	.....	.....
Physiotherapy	.....	.....	.....	.....
Occupatherapy	.....	.....	.....	.....
Financial Relief	.....	.....	.....	.....
Occupational Placement .	.....	.....	.....	.....
Other Needs	.....	.....	.....	.....

Status of Patient:

LIST OF LONG-TERM PATIENTS

Patients in Hospitals Over Three Months on June 21, 1923

(See page 128)

Sex	Age	Rate of Payment	Diagnosis	Number of Days in Hospital June 21, 1923
			In Public Institutions	
SAN FRANCISCO HOSPITAL—				
M	18	Free	Poliomyelitis	1 yr. 6 mos.
F	27	Free	Arthritis	1 yr. 3 mos.
F	43	Free	Abscess of arm	1 yr.
M	9	Free	Tuberculosis of hip and spine	9 mos. 26 days
M	48	Free	Diabetes mellitus, tendoplasty	9 mos. 11 days
M	56	Free	Cardiac decompensation	8 mos. 24 days
M	38	Free	Fracture and necrosis of right ulna	8 mos. 21 days
M	27	Free	Cardiac	8 mos. 19 days
M	71	Free	Carcinoma larynx	8 mos.
M	30	Free	Chronic arthritis	8 mos.
M	37	Free	Bronchiectasis, brachial palsy	7 mos. 9 days
M	24	Free	Ophthalmitis and keratitis	7 mos. 8 days
F	34	Free	Lung abscess	6 mos. 22 days
M	55	Free	Fracture left femur	6 mos. 18 days
M	11	Free	Osteomyelitis left tibia	6 mos. 8 days
M	59	Free	Cardiac	5 mos. 27 days
M	56	Free	Fracture left ulna and sprained left hip	5 mos. 22 days
M	52	Free	Chronic infectious arthritis	5 mos. 21 days
F	31	Free	Arthritis	5 mos. 13 days
M	11	Free	Cardiac	5 mos. 11 days
M	74	Free	Diabetic gangrene	5 mos. 2 days
M	40	Free	Acute arthritis	5 mos.
F	7	Free	Gonorrheal vaginitis	4 mos. 22 days
M	20	Free	Leprosy	4 mos. 19 days
M	23	Free	Tuberculous foot	4 mos. 11 days
M	67	Free	Appendectomy hernia	4 mos. 11 days
M	28	Free	Brain tumor	3 mos. 24 days
M	66	Free	Myocarditis	3 mos. 22 days
F	24	Free	Hypertrophied tonsils and sprained right ankle	3 mos. 17 days
M	48	Free	Fracture	3 mos. 16 days
M	6	Free	Cardiac	3 mos. 12 days
F	42	Free	Malaria	3 mos. 10 days
F	9	Free	Second degree burns	3 mos. 7 days
M	45	Free	Psoriasis and lues	3 mos. 7 days
M	57	Free	Fractured femur	3 mos. 7 days
M	47	Free	Raynaud's disease	3 mos. 4 days
M	23	Free	Fractured vertebra	3 mos. 3 days
M	41	Free	Anxiety neuroses	3 mos. 3 days
M	52	Free	Potts fracture	3 mos.

Total, 39.

UNIVERSITY OF CALIFORNIA HOSPITAL—

M	30	Free	Berger's disease	6 mos. 16 days
M	27	Free	Fracture right femur	6 mos. 21 days
M	25	Free	Compound osteotomy of femur	4 mos. 13 days
F	12 mos.	$.50 daily	Tumor left neck	4 mos.
M	28	$1 daily	Brain tumor	3 mos. 28 days
F	7	$.50 daily	Carditis old rheumatic fever	3 mos. 27 days
F	44	Free	Chronic endocervicitis	3 mos. 23 days
M	54	Free	Nephrectomy	3 mos. 16 days
M	40	Free	Teratoma	3 mos. 8 days
F	6	Free	Plastic for face burns	3 mos. 7 days

Total, 10.

In Privately Controlled Institutions

CHILDREN'S HOSPITAL—

M	7½	Free	Tuberculous hip (left)	6 yrs. 6 mos.
M	6½	Free	Tuberculous fistulae of abdomen	3 yrs. 4 mos.
F	4	Free	Tuberculous left hip	2 yrs. 8 mos.
F	7	Free	Birth injury spine	1 yr. 8 mos.
F	10	Full	Fracture left femur	1 yr. 7 mos.
F	8	Free	Tuberculosis left hip	1 yr. 5 mos.
F	7	$50 mo.	Tuberculosis both hips	1 yr. 5 mos.
F	7	Part pay	Osteomyelitis of left knee	1 yr. 4 mos.
F	..	$4 daily	Multiple arthritis	1 yr. 5 mos.
M	..	Part pay	Tuberculous hips	1 yr. 5 mos.
M	..	$25 mo.	Tuberculous hips	1 yr. 5 mos.
M	5	$1 daily	Tuberculous spine	1 yr. 4 mos.
M	11	$20 mo.	Tuberculosis of left hip	1 yr. 2 mos.
F	5	Free	Tuberculosis of spine	1 yr. 2 mos.
M	5	Full	Pott's disease	1 yr. 1 mo.
F	7	Full	Congenital dislocation hips	11 mos. 8 days
F	2	Free	Cervical Pott's	10 mos. 4 days
M	2	Free	Post infantile paralysis	8 mos. 25 days
M	3	Free	Tuberculous hips	7 mos. 19 days
F	5	Free	Tibias orthopedic	7 mos. 10 days
F	5	Free	Congenital hips	7 mos. 5 days
F	3	Full	Congenital hips	6 mos. 27 days
F	10 mos.	Free	Hair lip, cleft palate	6 mos. 25 days
M	10 mos.	Free	Hair lip, cleft palate	6 mos. 25 days
M	10	$5 weekly	Osteomyelitis left large toe	6 mos. 16 days
M	4	$1 daily	Congenital hips	6 mos. 14 days
M	6½	$1 daily	Diabetes mellitus	5 mos. 25 days
F	8 mos.	Free	Impetigo	5 mos. 15 days
F	6	$20 mo.	Second degree burns	5 mos. 9 days
F	Adult	$1 daily	Fibroids in uterus adhesions	5 mos. 6 days
M	10	$20 mo.	Post-infantile paralysis	4 mos. 27 days
M	8	$15 mo.	Tuberculous spine	3 mos. 25 days
M	13	$1 daily	Club foot	3 mos. 23 days
M	2	Free	General streptococcus infection	3 mos. 9 days
F	Adult	Free	Multiple arthritis	3 mos. 8 days

Total, 35.

FRANKLIN HOSPITAL—

M	33	$20 weekly	Pott's fracture	2 yrs. 6 mos.
F	52	Free	Total blindness	1 yr. 10 mos.
F	89	Full	Carcinoma uterus	1 yr. 1 mo.
M	..	Member	Senile decay	1 yr.
M	..	Member	Fracture femur	11 mos. 3 days
M	..	Member	Pernicious anemia	8 mos.
M	30	$20 weekly	Pott's fracture	8 mos.
F	..	Member	Fractured femur	6 mos. 8 days
F	50	Full	Spinal injury	6 mos. 8 days
M	80	$20 weekly	Compound fracture of leg	5 mos. 17 days
M	82	Member	Angina pectoris	4 mos. 21 days
M	64	Member	No diagnosis	4 mos.
M	52	$20 up	Spinal fracture	3 mos. 21 days
F	53	Member	Fracture femur	3 mos. 6 days
M	26	$34.65 wk	Compound fracture tibia and fibula; fracture radius and ulna	3 mos.

Total, 15

FRENCH HOSPITAL—

M	55	Free	Paralysis	3 yrs. 1 mo.
M	21	Free	Tuberculous hip	1 yr. 11 mos.
M	40	Free	Tuberculosis	1 yr. 8 mos.
F	78	Full	Senility	1 yr. 5 mos.
M	59	Free	Osteomyelitis	1 yr. 4 mos.
M	43	Free	Osteomyelitis	1 yr. 2 mos.
M	40	Free	Luetic	1 yr.
M	64	Free	Chronic rheumatism	1 yr.
F	78	Full	Hemiplegia	1 yr.
F	48	Free	Hemiplegia	11 mos.
M	30	Free	Osteomyelitis of right arm	4 mos. 6 days
M	22	Full	Malta fever	3 mos. 22 days

Total, 12.

LANE AND STANFORD UNIVERSITY HOSPITAL—

M	..	Full	Complications	1 yr. 2 mos.
M	6	Full	Permanent trachetotomy tube	1 yr.
F	2	Full	Permanent trachetotomy tube	7 mos. 25 days
M	..	Full	Extraction of cataract of right eye	7 mos. 9 days
F	..	Full	Tonsillectomy and appendectomy	7 mos.
M	..	Full	Mental	6 mos. 25 days
M	37	Full	Paretic	6 mos. 12 days
F	..	Full	Arthritis	5 mos. 28 days
M	35	Full	Syphilis	4 mos. 14 days
M	..	Full	Paresis	3 mos. 10 days
M	35	Full	Infectious granuloma	3 mos. 2 days

Total, 11.

MARY'S HELP HOSPITAL—

F	64	Full	Paralysis tongue	1 yr.
F	64	$40 mo.	Paralysis	1 yr.
F	50	Free	Inoperable carcinoma	8 mos.
F	75	Full	Senility	6 mos.
F	75	Full	Senility	5 mos. 12 days
M	4	$17.50 mo.	No diagnosis	4 mos. 7 days
F	68	Full	Fractured hip	4 mos.
M	37	Full	Carcinoma	4 mos.
M	27	Full	Infected arm	4 mos.
F	33	Two-thirds	Heart	4 mos.
M	77	Full	Prostate gland, etc.	3 mos.
M	53	Full	Fractured leg	3 mos.

Total, 12.

MOUNT ZION HOSPITAL—

M	..	Full	Enlarged prostate	1 yr. 5 mos.
M	..	Full	Transverse fracture lower and middle third femur	9 mos. 24 days
M	37	Full	Cardiac decompensation	6 mos. 7 days
F	20	Full	Acute diffuse lupus erythematosus	3 mos. 28 days
M	55	$10 weekly	Gastric carcinoma	3 mos. 12 days

Total, 5.

ST. LUKE'S HOSPITAL—

F	32	Full	Amebiasis and appendicitis	1 yr. 1 mo.
F	38	Full	Amebiasis	6 mos. 27 days
M	40	Full	Fractured leg	5 mos. 24 days
F	43	Full	Carcinoma breast	5 mos. 7 days
M	44	Full	Contracture of hand	5 mos. 2 days
F	..	Full	Feeding	4 mos. 28 days
M	32	Full	Appendicitis	3 mos. 19 days
M	40	Full	Fracture leg	3 mos. 11 days
F	..	Full	Tuberculous spine	3 mos. 7 days
F	26	Full	Ankylosed knee	3 mos. 6 days

Total, 10.

ST. MARY'S HOSPITAL—

M	..	Free	Arthritis	14 yrs. 10 mos.
F	..	Free	Severed spinal cord	10 yrs. 3 mos.
M	..	Free	Paralysis	6 yrs. 7 mos.
F	60	Free	Arthritis	3 yrs. 6 mos.
M	46	Free	Skin grafting—burns	2 yrs. 11 mos.
F	55	Approximately 75c daily, private room when possible.	Arthritis	2 yrs. 5 mos.
M	27	Full	Severed spinal cord	1 yr. 5 mos.
M	46	Full	Fracture back	1 yr. 3 mos.
F	..	Full	Carcinoma of breast	10 mos. 28 days
F	45	Full	Cerebral hemorrhage	5 mos. 5 days
M	..	$3.65, private room and 2/3 of extras.	Arthritis	5 mos.
F	49	Full	Excision portion seventh rib	5 mos.
F	46	Full	Carcinoma of breast	4 mos. 26 days
M	27	Full	Osteomyelitis of right tibia	4 mos. 24 days
F	65	Free	Chronic myocarditis	4 mos. 11 days
M	27	Full	Fracture right femur	4 mos. 3 days
M	54	Full	Osteomyelitis of femur	3 mos. 15 days
F	86	Full	Myocarditis	3 mos. 15 days
M	40	Full	Fracture tibia and fibula	3 mos. 11 days
F	80	Full	Fracture right leg	3 mos. 4 days

Total, 20